The Modern Hospital

JUNE 1960

How Electronics Will Change the Shape of Hospitals To Come

New designs, new materials, new ideas on hospitals will emerge from studies to be conducted at the proposed Atomedic research center (*page* 81)

Secretary Arthur Flemming: Man on the Firing Line

Cranberries, carcinogens and care of the aged are issues that have kept the spotlight on the Secretary of Health, Education and Welfare (*page* 92)

Organized Medicine Organizes To Combat Overutilization

How a board of prominent Pennsylvania doctors works with Blue Cross to reduce costs of hospital care by reducing abuse of facilities (*page* 99)

Student nurse kibitzes a checkers game in teen-age unit at Emanuel Hospital, Portland, Ore. (*page* 114)



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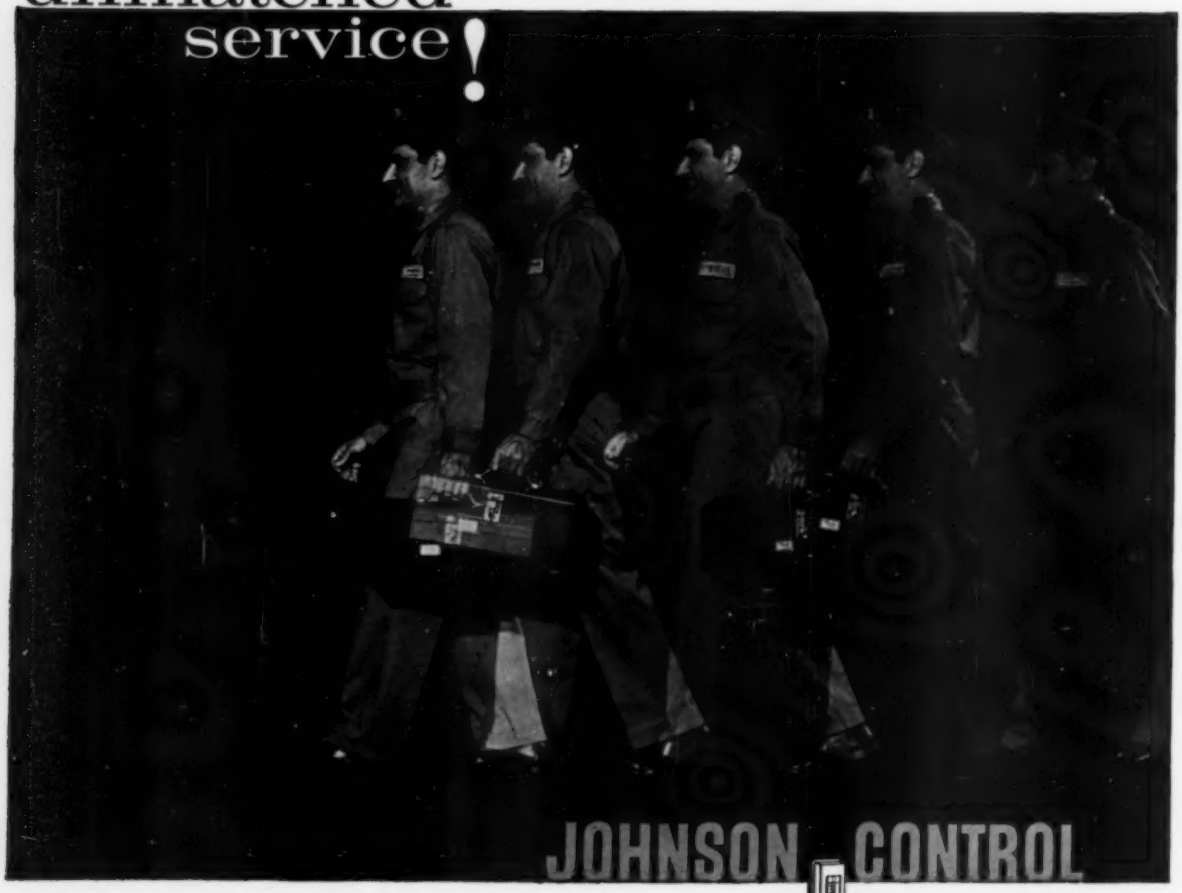
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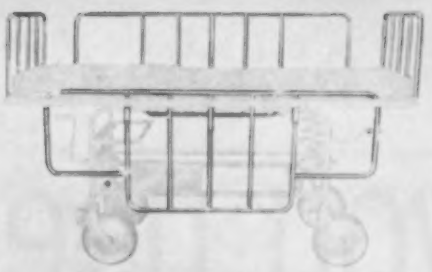


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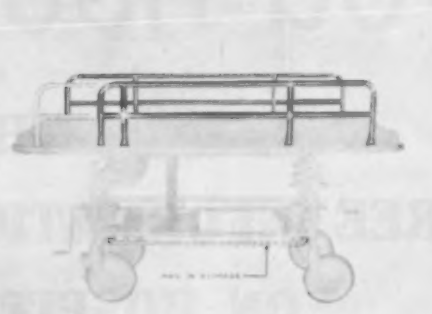
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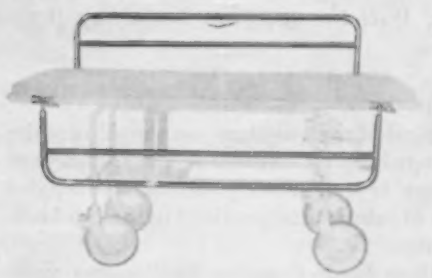
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The Modern Hospital

JUNE 1960 VOLUME 94, NO. 6

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ROVING REPORTER

TV Watches Patients During Cancer Therapy

Closed-circuit television keeps an eye on radiotherapy patients at Veterans Administration Hospital, Bronx, N. Y. This makes it especially important during high energy radiation for cancer therapy, because it provides the close-up view necessary with precision technics, the hospital reports.

The television camera, according to Dr. Bernard Roswit, chief of the radiotherapy service at the hospital, permits constant surveillance of the patient from any angle and almost any range. It thus replaces the special lead glass windows, which, he says, are expensive, difficult to install, and give a limited view.

The hospital uses a portable, remote controlled camera which is wheeled into the best vantage point, depending on the patient's position. During treatment the operator, from outside the room, can change lenses for wide angle or telephoto coverage, focus at various distances, pan and tilt the camera, all with three simple controls. The picture is viewed on a 17 inch monitor positioned so it can be conveniently viewed by the operator. He can observe the patient from any angle without the radiation equipment obscuring his view.



Portable television camera system allows operator best possible view of the patient by remote controls.

"This function is particularly important when the objective of irradiation is cure, and high dosage is administered with precision technics. Especially is this so when high energy radiation, such as cobalt 60 and multimillion volt x-rays, are employed. With such equipment, the risk of injury to normal tissues through patient movement is great and must be avoided through . . . dependable surveillance technics. For this purpose, closed video does an outstanding job," Dr. Roswit stated.

The hospital is presently investigating a method that may make it possible to observe the patient's tumor on the video screen as it is bombarded by the two million volt cobalt beam, according to Dr. A. M. Kleinman, manager of the hospital.

Until now, the image produced by these rays has been poor, he reports, as seen on a fluoroscopic screen and transmitted via television. However, Dr. Kleinman and Dr. Roswit hope that the introduction of a special photoluminescent crystal or "viewing glass" may prove successful in the near future.

Picture Patients' Feelings

Baby pictures used to portray attitudes toward hospital charges call attention to a new booklet prepared by St. Joseph's Hospital, Lancaster, Pa.

Called "What Price Health?" the 12 page publication tells why hospital rates are high and traces the steady cost climb. It also lists what patients receive for their money, pointing out that even at present high rates the patient pays only part of the bill.

The booklet also gives specific figures on the hospital's sources of income and what its expenses are.



A new mother enjoys baby pictures as she learns about hospital costs.



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READER OPINION

Pioneer in Queuing Theory

Sirs:

The excellent article, "How Queuing Theory Works for the Hospital" in the March issue of The MODERN HOSPITAL, cites a number of examples of the application of the Poisson Distribution to hospital situations.

Surprisingly, it does not call attention to the earliest and probably most important application, developed by C. Horace Hamilton during his pioneer work with the Commission on Hospital Care. Dr. Hamilton pointed out that under "normal" conditions, the variation in the flow of patients to hospitals follows the Poisson Distribution.

From this, he concluded that if the probability of a waiting list is fixed, hospitals which serve larger populations (those with relatively high average daily census) would have higher occupancy rates than hospitals which serve smaller populations. This led him to conclude that a community will require fewer beds if these beds are in fewer independent units.

Although it is well known in the hospital field that occupancy rates do tend to vary directly with the number of beds in hospitals, it is frequently suggested that this results from internal characteristics of hospitals rather than from the nature of the variation in demand for hospital service.

With the support of the United States Public Health Service, the Hospital Council of Western Pennsylvania is presently engaged in research in 15 selected hospitals in an attempt to identify feasible hospital practices that might tend to reduce the expected variation in daily census and thereby permit hospitals to function effectively at higher rates of occupancy. Results of this research should be available within two years.

Robert M. Sigmond
Executive Director
Morris London
Research Associate
Hospital Council of
Western Pennsylvania
Pittsburgh

Defends Male Nurse Title

Sirs:

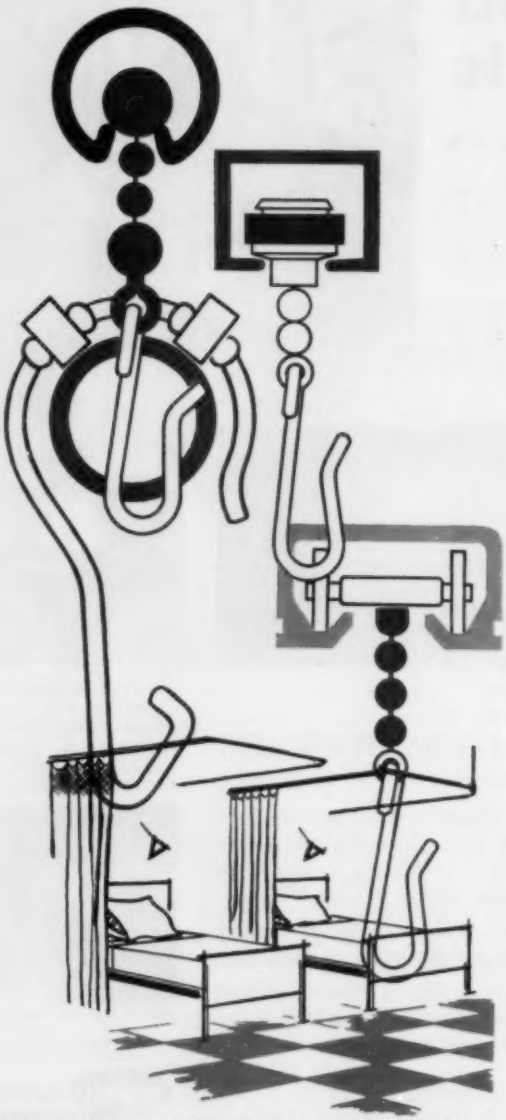
I have read both the article (Mr. R. N. Is Wanted on the Nursing Team, December, p. 71) and the letters discussing male nurses in your magazine. I noted that some of your correspondents are in favor of changing the title of the male registered nurse to something else. I can only ask: Why?

The argument over whether a male nurse should be called something else has no more bearing on his professional standing than the old argument over whether a nurse should or should not wear a uniform other than white. If the person is secure within himself, I can see no reason why he should object to being called a nurse. He is using the correct title of a member of a profession that has an honorable occupation and a record of service to mankind. As for myself, when someone asks me what I do, I reply "I am a registered nurse."

John Gold, R.N.
Mansfield Depot, Conn.

(*Continued on Page* 10)

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New Light on Heating

Sirs:

For many years I had had a profound respect for Charley Neergaard and an awareness of his contributions to hospital planning and design. But in my judgment there was no justification for the concluding paragraphs of his article on Radiant Heating. It's just "Hot Air."

It so happens that the Long Island Jewish Hospital, shortly to be expanded from 235 beds to 500, probably is the largest hospital having radiant heating throughout, and incidentally radiant cooling. As the architect I emphatically deny that anyone associated with the design failed to properly scale down the boiler capacity or had neglected to take advantage of all possible savings because of the design.

To imply, as he does, that but few architects and engineers would recommend radiant heating because the size of the heating plant could be reduced and thus "halve the architects' or engineers' fee" is to charge dishonesty and is sheer nonsense. Neergaard knows better, as should The MODERN HOSPITAL.

Louis Allen Abramson
Architect

New York

Figure Didn't Balance

Sirs:

We have received several letters concerning the article on balancing the school of nursing budget (The MODERN HOSPITAL, April 1960) calling our attention to an unaccountable error that somehow managed to slip by all of us.

On the bottom of page 105, the last sentence reads, "Our tuition has been $425 a year for the last four years. . . ." This should have read, "Our total tuition has been $425 per student for the last four years."

We certainly hope that this error has not confused readers of the article, especially because the point about low tuition is such a fundamental thesis for the whole paper.

Thomas Hale Jr., M.D.
Director

Albany Hospital
Albany, N.Y.

A FABLE BOTH OLD AND NEW

Once upon a time there lived a man whose name was Franklin. His parents named him Benjamin. And this man was a person of great wisdom and influence among the people. One day there came to him three medicine men, learned and much renowned in their day. They asked Benjamin Franklin's approval and help in establishing an institution to which the sick might be brought and where they would find warmth and food, and the services of physicians. By his influence with the holders of the public purse, this was done.

Rapidly, as the country grew in people and wealth, more and more and more such places of refuge for the sick came into existence. After the passage of many years, the buildings now known as hospitals grew in complicity, in efficiency, in cost. And the people found they could not pay for care when sickness devastated individuals and families. And the citizens were sore afraid.

Now the wise men of the community began to seek for a way to care for these unfortunate afflicted ones. And as they searched, lo! one day a great fowl known as a goose appeared among them. This goose was of the family known as Blue Cross. The goose was no ordinary fowl which it soon proved by beginning to lay golden eggs. Now the wise men soon saw that here was the answer to their seeking and the golden eggs were more than capable of sustaining the institutions of the sick.

But the cost increased and soon those in authority began to demand that the goose work harder and lay more and heavier eggs of gold. And this feathered benefactor exclaimed, "I am doing all I can. If I lay more eggs of gold my strength will fail and I will die." Those in authority waxed wrathful and beat the goose and reviled it with words both unkind and devoid of gratitude.

And so one day, after such denunciation, the leaders of the places for the sick slew the goose that laid the golden eggs and the hospitals knew its help no more. Then those men of the government who talked loudly but did little except for favors expected took over the peoples' hospitals and medicine called socialized now prevailed. — JOSEPH C. DOANE, M.D., *former editor and chairman of the editorial board of* The MODERN HOSPITAL.

NEW PRODUCT INFORMATION

For more details about the new products described on this page, check appropriate numbers on coupon at bottom of page.

SPRAY-ON DRESSING—This new product named SCAN* Spray-On Wound Dressing forms a smooth, tough, transparent film that is an obstacle to bacteria and is insoluble in water or body fluids. This film conforms well to any body contour and allows flexing freedom without becoming cracked or split.



The Dressing is easily removed, or in time will slough off by itself. Suggested for use as an insoluble dressing in pediatric surgery, a dressing for any small dry wound, a prophylactic covering over gauze dressings, and hard to bandage areas such as fingers and toes.

SCAN Spray-On Wound Dressing is packaged in an aerosol can for ease of application.

Circle #375 on Information Request Form for additional literature.

TWO FAMOUS PRODUCTS COMBINE TO MAKE NEW K-S COMPRESSION ROLL—KLING* Conform Bandage and surgical viscose rayon padding have been combined to make a new compression roll. The amazing properties of KLING Conform Bandage give K-S* Compression Roll abundant stretch for safety in case of swelling, and self-adherence which makes bandaging faster and neater. The viscose rayon padding



provides ample absorbency, cushions the wound, and is comfortable to wear.

Suggested uses: leg roll, burn dressing, stump dressing, head bandage, radical mastectomy dressing, large skin grafts and whenever an absorbent compression dressing is indicated.

Circle #376 on Information Request Form for additional literature.

BLUE COLOR IDENTIFIES X-RAY DETECTABLE SPONGES—The new iridescent blue monofilament in RAY-TEC* x-ray Detectable Sponges is more readily seen under operating room lights both before and after saturation in blood. The color is a mineral substance which is inert and insoluble in body fluids. The filament makes a large three-dimensional



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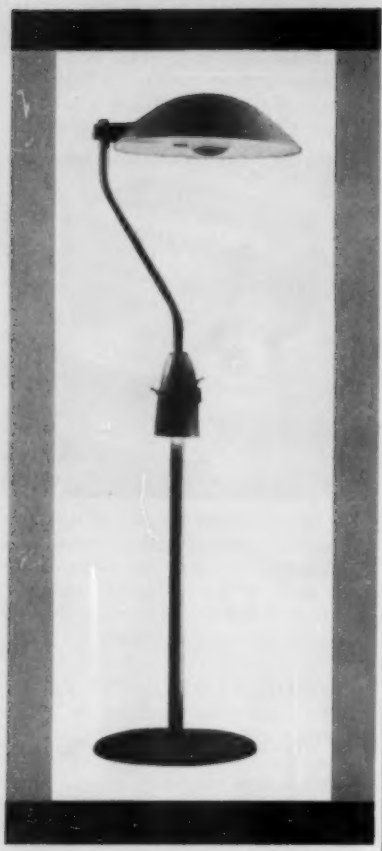
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Schools Manage To Get the Money They Need; Why Don't Hospitals?

By Gordon Davis

PERHAPS you, too, have been entertained by the screams of anguish that emanate from eminent educators whenever there is a threat, actual or implied, of economic checks, restrictions or restraints on the progress of the schools.



Gordon Davis

Entertained . . . and probably impressed. There's no doubt about where the educators stand. They are out for enough money to build the kinds of schools and attract the numbers of teachers they think they need, today and tomorrow. They don't care who knows it; in fact, the whole show is put on to make certain that the public can't help but know it.

And there is no doubt that they have been getting what they wanted.

The cost per pupil-day of elementary education has risen more during the past decade or so than the cost per patient-day of hospital service. It is being seriously argued by prominent pedagogs that teachers' pay must go up a whopping 50 per cent to nearly $7500 annually within the next three or four years.

But do the soaring costs of education come in for scathing editorials, public hearings, and demands for state regulation? Not so you could notice it. The earnest taxpayers can't seem to shell out fast enough for upbuilding the educational system, grumbling the nonce, perhaps, but nonetheless digging deep.

Why the schools and not the hospitals? Obviously, because the schools have done a far better job of publicizing their economic needs. School leaders have sold themselves so thoroughly on the rightness of their mission that they nearly have hysterics if they don't get everything they want.

By way of contrast, no hospital spokesmen seem willing to test their lungs on the economic question, to threaten the very probable catastrophes in health care if the financial needs of the hospitals are not met, to pound the public table over inadequate hospital salaries, to tangle instantaneously with all careless critics of rising costs — newspaper editors, legislators, skeptical citizens, or what have you.

School superintendents do this. School board members do it. College presidents do it. And they get many other people to pitch in with them — citizens groups, chambers of commerce, industrial leaders, parents' organizations, even labor and taxpayers' groups.

Interestingly enough, the public relationships of the schools as a whole are far from perfect, as any reader of the press cannot help but observe. The inadequacies of our educational system — "Why can't Johnny read?" — have been plastered on front pages from coast to coast. But even as they have protested over the quality of what they are getting, the people have been willing to pay more and more to obtain it.

Again, compare hospitals. The quality of today's hospital care is rarely questioned. Almost all the argument is over what it costs.

Ridiculous? Of course. It's the price to hospitals of not taking the trouble to keep the public informed about their economic needs — or perhaps of not thinking it's important to do so. ■

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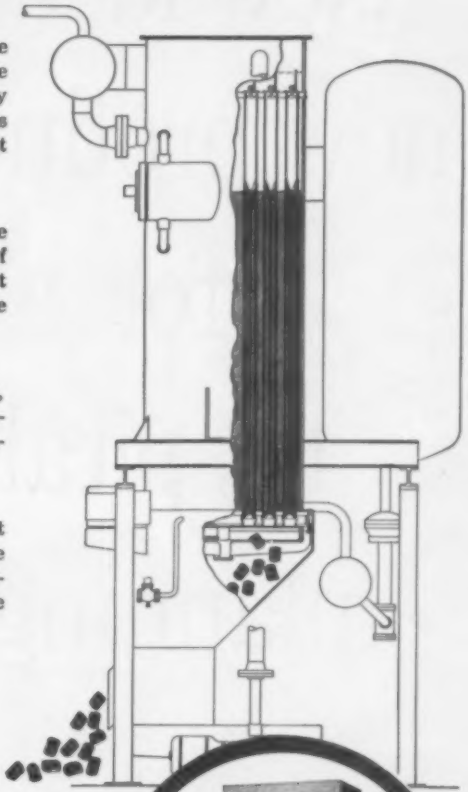


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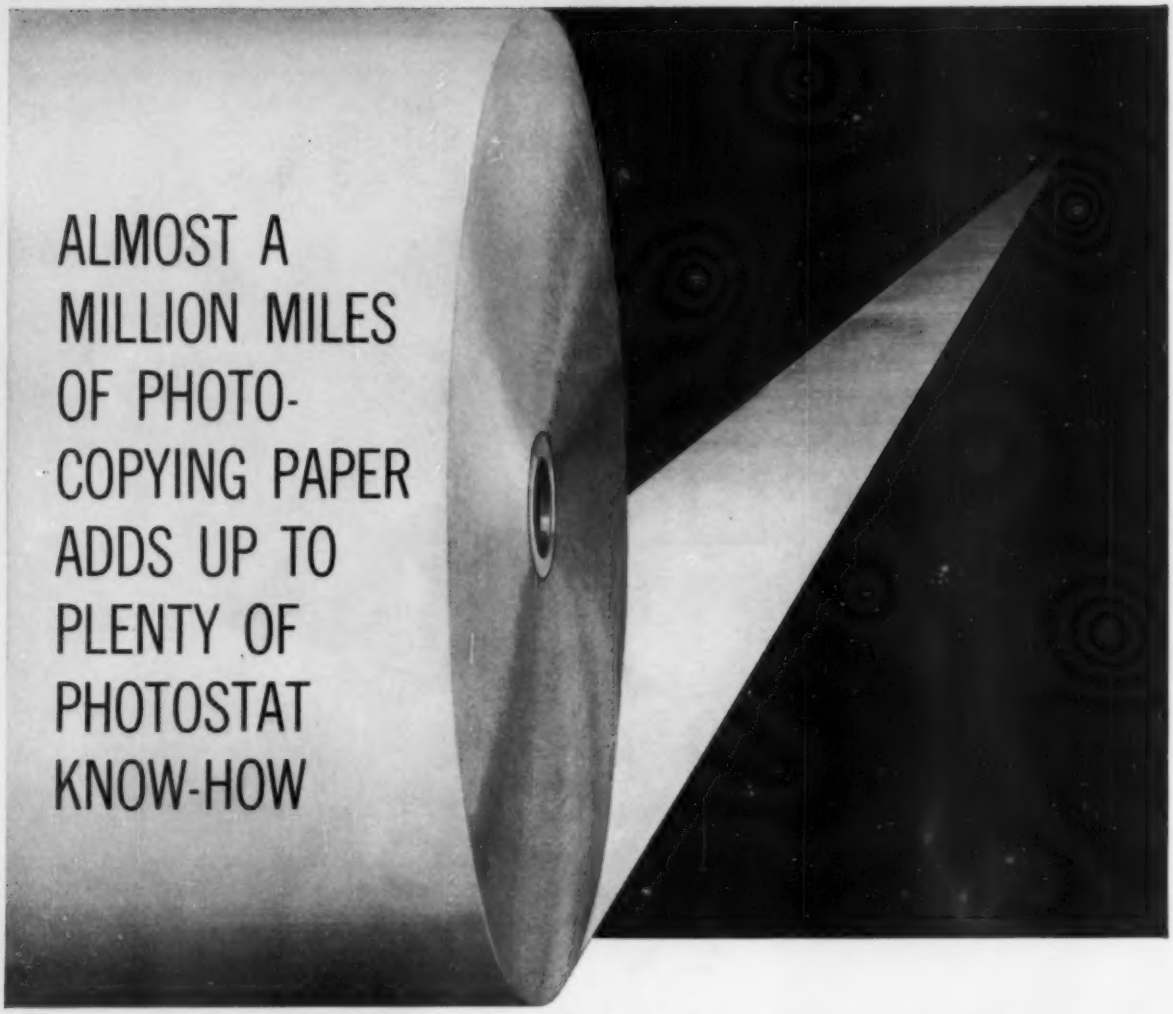
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Closer Control of airborne contamination in hospitals seen, as researchers reveal new findings

In a study of St. Barnabas Hospital, Minneapolis, Minnesota, researchers looked into a practical method for reducing one of our biggest headaches in hospitals.



Newell P. Weed, Jr., Chairman
Trustees' Building Committee
St. Barnabas Hospital
Minneapolis, Minnesota

"The results of this study are very encouraging," reports Mr. Newell P. Weed, Chairman of the Trustees' Building Committee of St. Barnabas Hospital. "While the tests are of a preliminary nature and could be subject to variation, the results are regarded by bacteriologists as *typical*. We hope they will prove to be a significant step toward the control of airborne contamination in hospitals."

Tests at St. Barnabas Hospital point to the elimination of a dangerous source of infection

Findings reveal that Electronic Air Cleaners significantly reduce airborne bacteria and mold spores

"When we planned our 306 bed new general acute hospital, we anticipated the problem of airborne contamination," says Mr. Newell P. Weed, Chairman of the Trustees' Building Committee of St. Barnabas Hospital. "We were aware that one way in which contaminated air is introduced into a building is through its air conditioning system. To reduce this hazard as much as possible, we installed an Electronic Air Cleaner in every fan system.

"We were convinced that electronic air cleaning was the best available method for reducing airborne dust and dirt. However, to our knowledge, little objective research had been done on its ability to remove bacteria from circulated air in hospital installations. Therefore, we decided to study our own installation upon its completion in 1959, to determine its efficiency in removing airborne bacteria and mold spores."

TEST PROCEDURES:

On November 23, 1959, two tests were made of one of the Honeywell Electronic Air Cleaner installations at St. Barnabas Hospital. The first test was made at 8:05 a.m. The second was made at 11:55 p.m.

Airborne bacteria and mold spore samples were taken from the air before and after it had passed through the electronic air cleaning system. The system contained a pre-filter. Each sample was collected through a Casella slit sampler for five minutes. This gave a total sample volume of five cubic feet. The airborne particles were accelerated at a great enough velocity in passing through the slit to cause them to impinge on a rotating agar-filled petri dish beneath the slit.

The samples were then cultured, and the bacteria and mold spore counts made.

RESULTS:

The *unretouched* color photographs on the opposite page show petri dishes containing the cultured samples taken from the two locations in the air handling system. The bacteria and mold spore counts are listed in the table at the right. The significant reduction in airborne bacteria and mold spores reveal the efficiency of the electronic air cleaning system.

The variation in the two samples at location A taken at different times of the day is attributed to the difference in bacteria and mold spore generation at those times. At 8:05 p.m., there was considerable activity within the building; traffic outside the hopsital was heavy. Later, at midnight, there was little inside or outside activity.

Bacteria and Mold Spore Counts

	Time: 8:05 p.m.		Time: 11:55 p.m.	
	Location A	Location B	Location A	Location B
Colonies in 5 Cubic Feet	127	7	13	1
Total Colonies Per Cubic Foot	25.4	1.4	2.6	0.2

LOCATION A

before passing through the Electronic Air Cleaner



COUNT: 25.4 colonies per cubic foot

TIME

8:05 P.M.

LOCATION B

after passing through the Electronic Air Cleaner



COUNT: 1.4 colonies per cubic foot



COUNT: 2.6 colonies per cubic foot

TIME

11:55 P.M.



COUNT: 0.2 colonies per cubic foot

Honeywell Air Cleaning Systems assure the best possible protection against airborne contamination

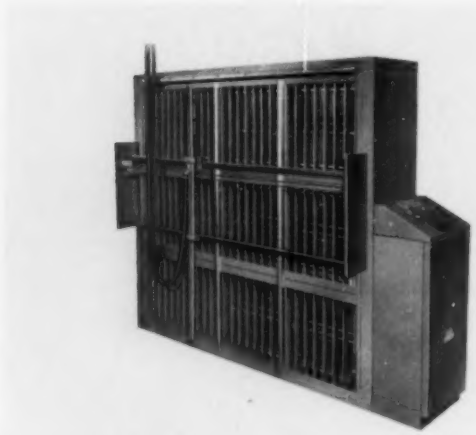
Honeywell offers you a combination of the Honeywell Electronic Air Cleaner and Activated Charcoal Filter in the world's finest air cleaning system.

A Honeywell Air Cleaning System will remove 90% of all dirt that passes through your air conditioning system—trap particles as small as 1/2,500,000 of an inch. It will also prevent the accumulation of dust and dirt in your ventilating ducts. This, too, can be a dangerous source of contamination.

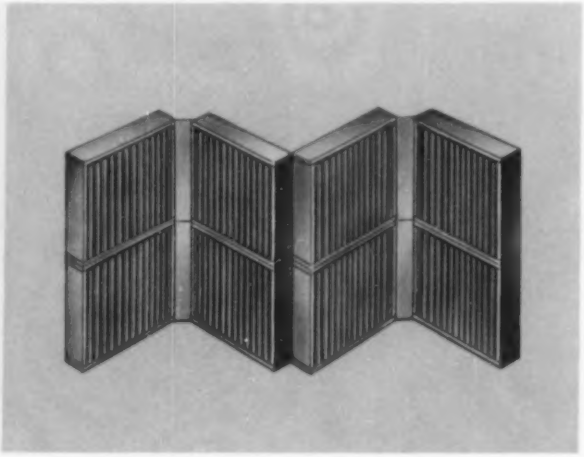
It will remove odors—help cut your air conditioning costs because less outside air is needed for ventilation. And, in some cases, it will enable you to install a smaller air conditioning system, thus offsetting its own cost.

A Honeywell Air Cleaning System will assure a fresh, clean atmosphere throughout your hospital—contribute to patient comfort, lower cleaning and redecorating costs and help promote a more efficient nursing staff.

For additional information about Honeywell Air Cleaning Systems, call your architect or engineer. Or write Honeywell, Dept. H-60, Minneapolis 8, Minnesota.



Honeywell Electronic Air Cleaner removes 90% of all airborne dirt



Honeywell Activated Charcoal Filter removes odors

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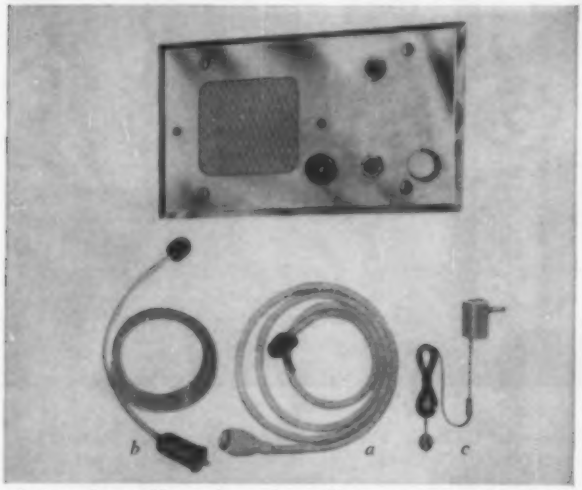
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▲ *The nurse may talk to patients from her station, monitor their rooms, cancel their signals.*



▲ *Interchangeable cord sets for calls from: a. normal patients; b. patients who cannot speak or hear; c. oxygen-tent patients.*



▲ *Remote reply units enable the nurse to accept calls and talk to patients from locations away from her station.*

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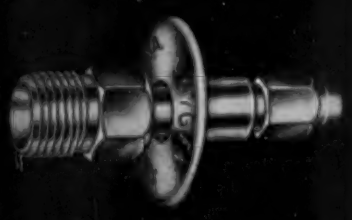
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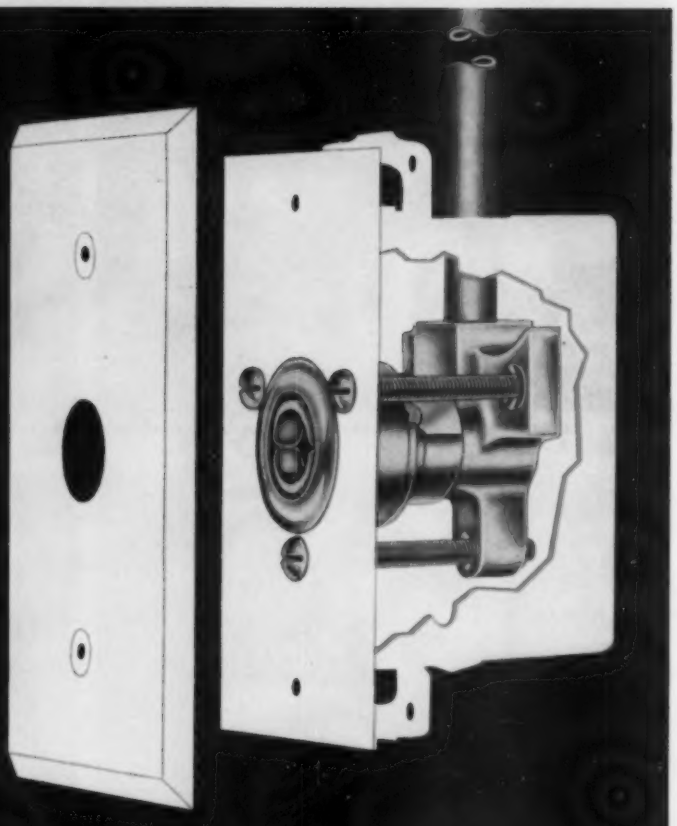
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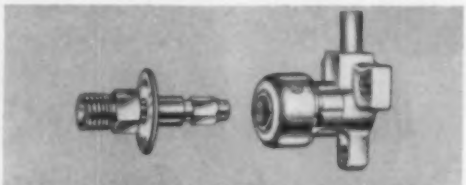


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There's a Schrader safety keyed check unit and adapter for every medical gas service.



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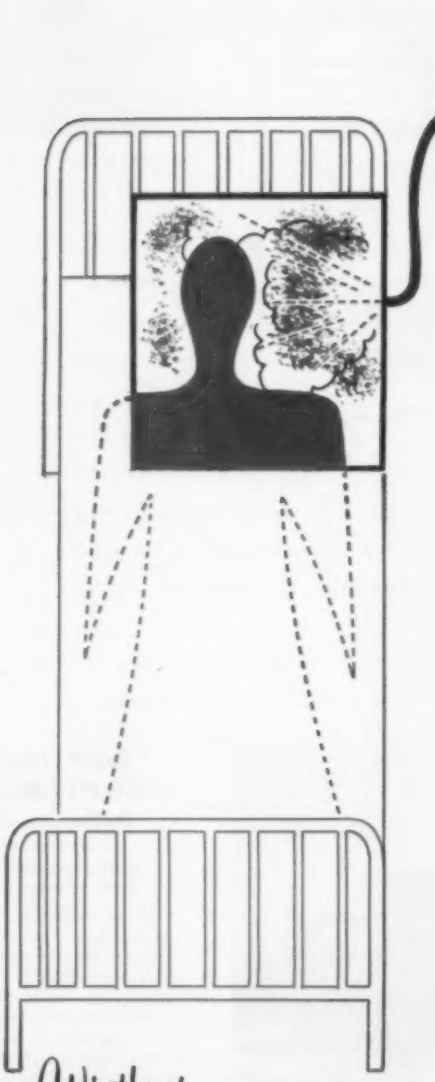
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Depending upon the output of the nebulizing device 1 bottle (500 cc.) is usually sufficient to last from eight to twenty-four hours.

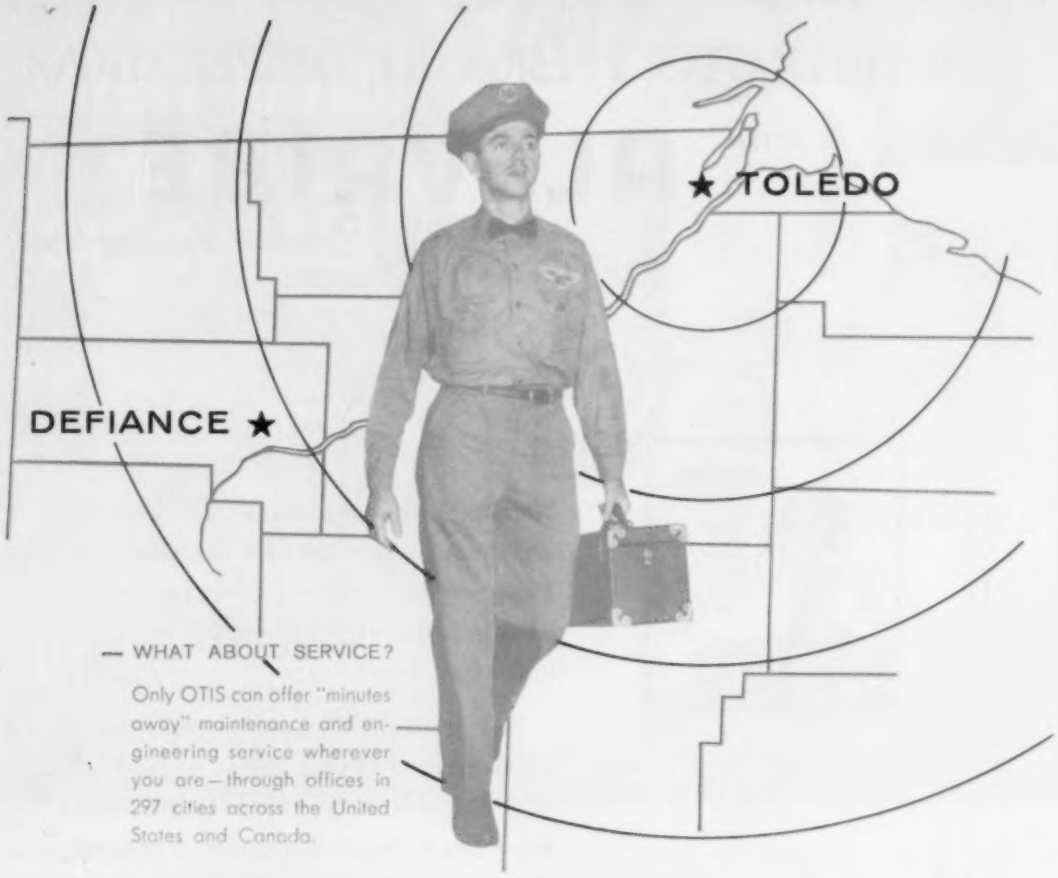
Supplied in bottles of 60 cc. and 500 cc.

Winthrop LABORATORIES
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1. Sadove, M.S.: Paper read at Meeting of the Champaign County Medical Society, Champaign, Ill., Mar. 12, 1953.

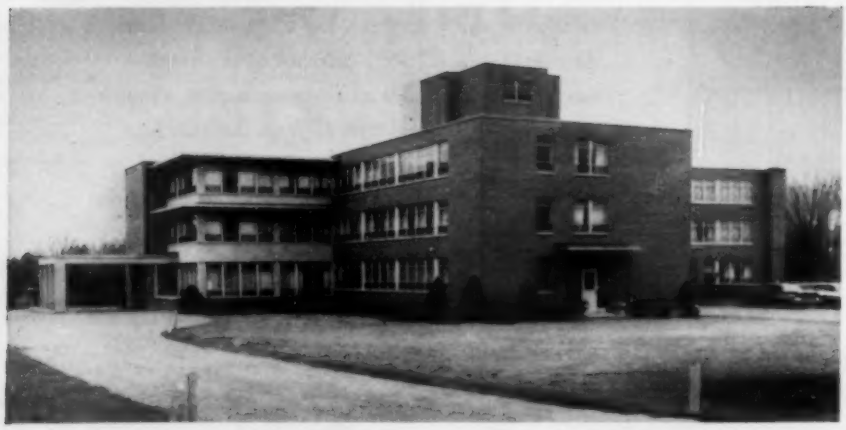
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DEFIANCE HOSPITAL, constructed and owned by the City of Defiance, is leased and operated by a non-profit corporation known as Defiance Hospital, Inc. This hospital has been a constantly growing institution in a population area of approximately 30,000. It opened in August 1951 as a 63 bed institution and was enlarged in 1957 to 94 beds and 20 bassinets. The number of patients treated each year has always exceeded the previous years.

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neighborly touch of maintenance by local men"



HOMER W. CONNOR
Administrator

"We have a highly satisfactory elevator situation here at DEFIANCE HOSPITAL," says HOMER W. CONNOR, Administrator.

"In July 1957, we added a second passenger elevator. It is an OTIS, the world's finest. At the same time we put it under OTIS MAINTENANCE.

"To date, we have had only two minor trouble calls in addition to our regular examinations. These calls were handled with a promptness that was mighty reassuring when you consider the importance of uninterrupted elevator service in a hospital.

"Another thing we like about OTIS Maintenance is the use of local men with their local viewpoint and firsthand knowledge of the ideals that have built the fine reputation of our hospital. These men have a local pride in the performance of our OTIS Elevator.

"In addition, it's nice to know that we have local men in a world-wide organization like OTIS who are highly qualified by factory-and-field training and experience to give unexcelled service."

elevator maintenance

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THAT KEEPS ELEVATORS RUNNING LIKE NEW

OFFICES IN 297 CITIES ACROSS THE UNITED STATES AND CANADA

How *Imaginative Engineering* Put Taming Chicago's



John Dolio (right) in front of Powers Graph-O-Matic Control Panel with E. S. Anderson, engineer for the Illinois Psychiatric Institute.

The unusual temperature requirements specified for the new Illinois Psychiatric Institute presented an extraordinary challenge for John Dolio & Associates. This Chicago engineering firm was asked to provide an absolutely uniform temperature throughout the 11-story, T-shaped building. Because temperature variations cause extreme discomfort —even pain—to mental patients, the system had to be accurate, foolproof and automatic. Because Chicago temperatures rise or fall to extremes within hours—sometimes minutes —the system had to be capable of sensing the changing weather picture outside and automatically and simultaneously reacting inside.

The resulting design provides all the answers . . . in a Powers pneumatic control system that operates automatically 24 hours a day—every day—at a bare minimum of cost; a system that compensates instantly for sudden outdoor temperature changes; a system that can be checked and controlled by one man.

The result is a functional system of control where practical engineering principles were combined by the Dolio firm with a strong helping of ingenuity in order to whip some of the more unusual problems. For example, since chilled water was to circulate through ceiling heating-cooling panels, a safeguard against condensation was necessary. The engineers solved this problem with a series of dew point controls mounted at various locations in the ceilings. Thus, "controls on a control" prevent water temperature from falling to the point at which condensation could occur.



Phil Derrig, Chief Mechanical Engineer of the Dolio firm, inspects one of the dew point controls specially designed to prevent condensation of cold water in the ceiling heating-cooling panels.

Powers Temperature Control To Work Weather At Illinois Psychiatric Institute

Illinois Psychiatric Institute
Chicago, Ill.

Illinois Supervising Architect:
Louis H. Gerding
Architects:
Shaw, Metz & Associates, Chicago
Associate Architects and Engineers:
Fugard, Burt, Wilkinson and Orth
Consulting Engineers:
John Dalio & Associates, Chicago
Heating, Air Conditioning Contractor:
Gallaher and Speck, Inc., Chicago
Ventilation: Zack Co., Chicago



JOB DETAILS

The system encompasses 12 temperature zones, each designed to operate independently in relation to individual zone exposure problems. Ten zones utilize ceiling heating and cooling panels at which hot and chilled water circulate from zone exchangers. Three-way control valves for the water are modulated by pneumatic thermostats in various rooms. Two zones — auditorium and stairwell — have only heat exchangers (the auditorium is supplied with individual conditioned air).

Master outdoor controls sense the changes in temperature outdoors and instantly reset submaster pneumatic thermostats at the zone exchangers. These indoor-outdoor controls are engineered for foolproof maintenance of uniform zone temperatures.

A central control board, the heart of the Dalio design, monitors the complete heating, cooling and ventilating system. The building engineer alone can instantly check 170 control points by merely referring to the Powers Graph-O-Matic Control Panel.

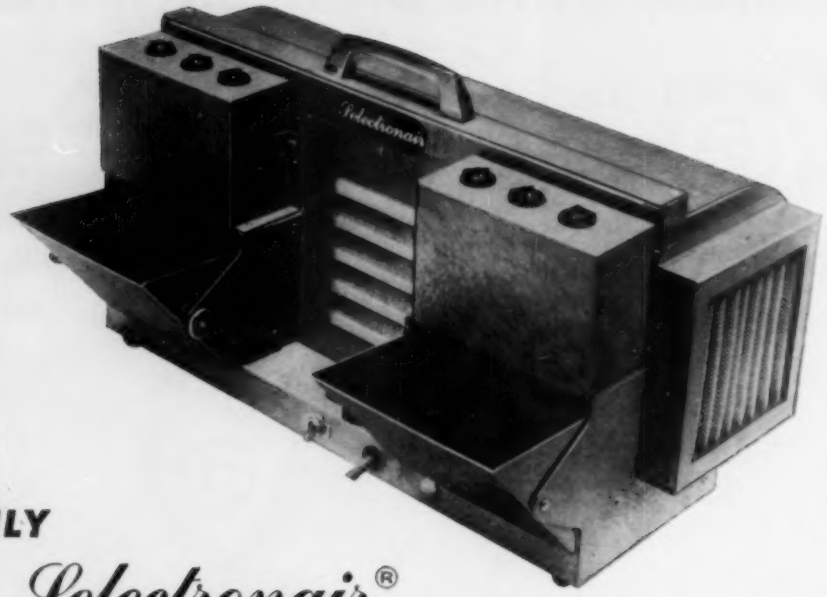
Temperature controls are inaccessible to patients. All controls in the corridors are wall-mounted and cabinet-enclosed; temperature sensors are mounted in ceiling exhaust ducts.

Easy servicing and low maintenance are two big reasons why a pneumatic system of control was specified by this engineering firm. Efficiency at low cost is characteristic of this type of control — as it is with the Powers pneumatic system installed here.

Safety and comfort for patients is provided for throughout. For example, in hydrotherapy, in showers, in sitz baths, etc., Powers Hydroguard® thermostatic water controls prevent scalding and eliminate dangerous water temperature fluctuations.

Write for the latest Powers Hospital Catalog.
Write us also for catalog on time-saving, money-saving pneumatic tube systems manufactured by our new subsidiary, the Grover Company.

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DEPT. 660 — SKOKIE 57, ILLINOIS | *Offices in Principal Cities in U.S.A. and Canada*
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THESE ARE THE REASONS:

- Industrial type fans move the air at 120 cubic feet per minute.
- Permanent washable filters screen out pollen and dust to one micron. (39 millionths of an inch).
- Separate filters for each blower.
- Air is forced through the rays of 2 separate banks of 3 lamps. The concentration of either the germicidal or the "odor out" mercury lamps may be instantly controlled. This feature (patent applied for) and directions for its application is covered by a chart furnished with each instrument.
- Selectronair is in reality two machines in one.
- Finger tip controlled vents direct air movement to all areas of the room.
- Selectronair may also be installed instantly, in a window to bring in purified outside air. Adjustable spacers are provided to give a snug fit.



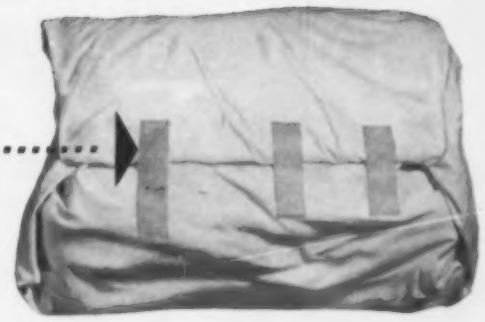
Write for our booklet, "Breathe and Sleep", together with the York Research Report.

Selectronair is distributed through merchants who feature sick-room and surgical supplies.

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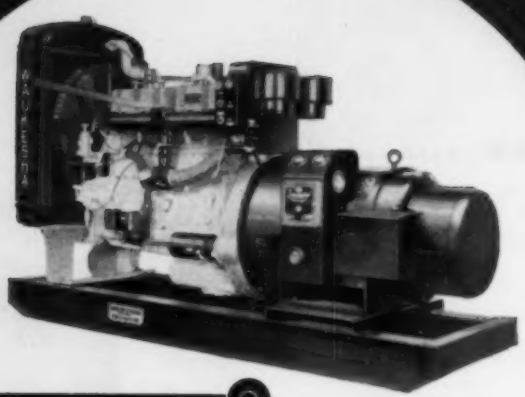
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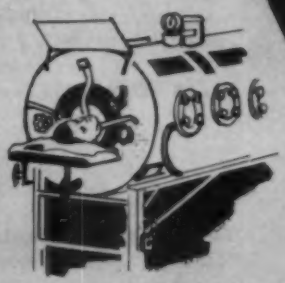
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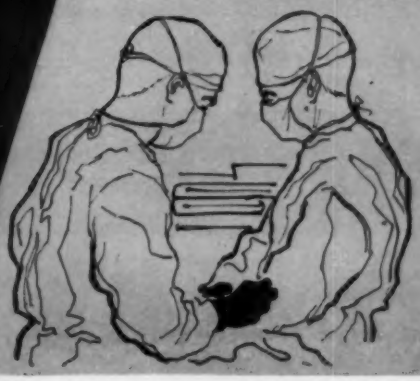
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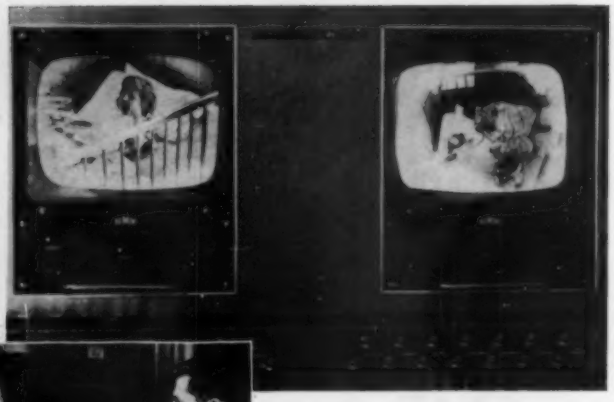
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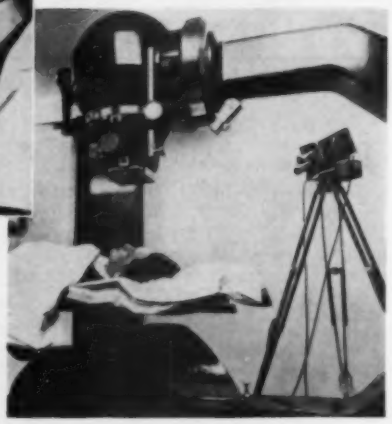


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Du Mont closed circuit TV—at this moment... is supplying hundreds of extra eyes in hospitals everywhere...







For Example:

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citrus	1 glass
apple	50 glasses
grape	9 glasses
pineapple	3-4 glasses
prune	50 glasses



†Data calculated from: Watt, B. K. et al., U.S. Dept. Agric. Handbook No. 8, 1950; and Burger, M. et al. Agr. & Food Chem. 4:418, 1956.

*This is the peak of the Recommended Daily Allowances for adolescence or pregnancy; 150 mg. during lactation; 70-75 mg. for normal adults.



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the Ames idea: through simpler diagnostics... standardized results... manpower savings

There is no panacea for those universal hospital problems—rising costs and shortage of skilled help. But for many hospitals, a step in the right direction has been adoption of the AMES idea: the simpler the procedure, the less chance for costly error in execution and interpretation.

With this idea in mind, AMES through research has pioneered and perfected a growing line of *standardized* diagnostic products. The most rigorous *quality control* during every phase of production assures the *uniformity* and *reproducibility* of results that hospitals require.

In routine urinalysis, AMES Reagent Tablets are so simple to use that untrained as well as trained personnel obtain the same dependable, standardized results. The newer AMES Diagnostics are based on an even easier "dip-and-read" technique. And from one to three determinations can be made with one reagent strip.

Since there is no preparation of solutions or clean-up afterward, and these tests are actually performed in seconds, skilled technicians are freed for more demanding tasks.

Your AMES representative will welcome an opportunity to explain how AMES Diagnostics can achieve standardized results and save time and money in your hospital.

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AMP
ALL-ELECTRIC HOSPITAL BED
the FOREMOST in electric bed design and efficiency



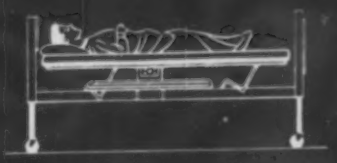




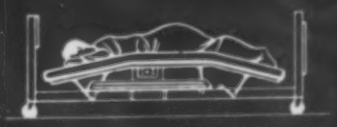
The amp bed is listed by Underwriters' Laboratories, Inc., for use with oxygen administering equipment.

We invite your inquiry

Here are a few of the medical positions provided by the AMP All-Electric Bed



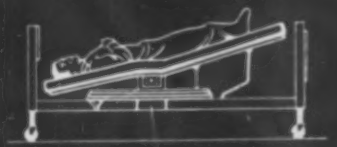
HIGH PRONE POSITION



REVERSE SPINAL POSITION



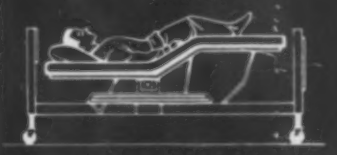
SPINAL HYPEREXTENSION



TRENDELENBURG POSITION



REVERSE TRENDELENBURG (Head Traction) POSITION



VASCULAR POSITION



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EARLY AMBULATION POSITION

HIGH-ENERGY RADIATION

maxitron 2000

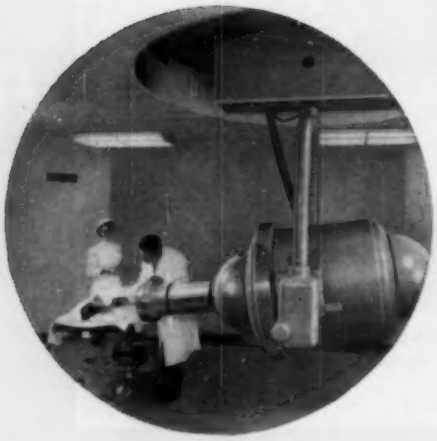
high dose rates at low cost per rad

2-MILLION VOLT X-RAY UNIT—the culmination of more than half a century's experience with radiation. Maxitron 2000 is the most powerful in the complete range of x-radiation therapy sources offered by General Electric.

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For full facts on any range of x-ray therapy equipment, see your G-E x-ray representative. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room 1003F.

Maxitron is a G.E. registered trademark.



maxitron 1000

MILLION-VOLT X-RAY UNIT—Maxitron 1000 super-voltage therapy unit combines high-energy output, easy operation and duplication of dosage—thanks to *electronically generated* radiation. Here again General Electric quality has reduced maintenance per thousand rads to just *pennies*.

Progress Is Our Most Important Product

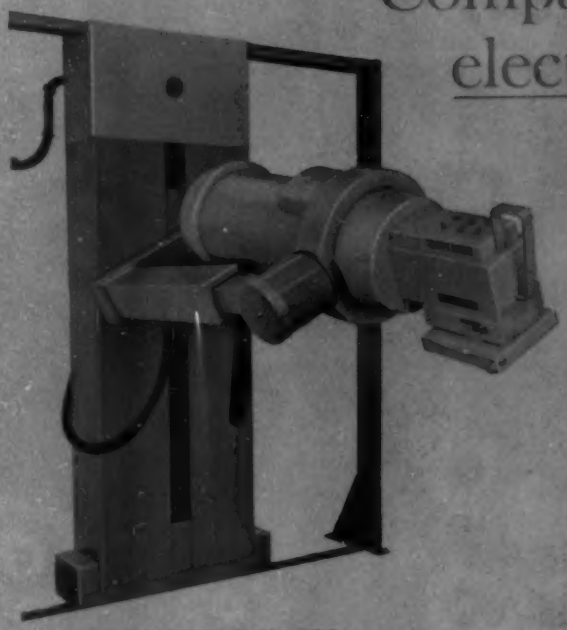
GENERAL ELECTRIC



BAYLOR UNIVERSITY MEDICAL CENTER, DALLAS, TEXAS...
2-million volt G-E Maxitron 2000—one of the many now in service at key institutions across the continent. Pleasant surroundings encourage even apprehensive patients to rest easy during therapy.

DEEP, INTERMEDIATE AND SUPERFICIAL THERAPY

Compare these powerful electronic x-ray sources



MAXITRON 300

Deep to superficial technic . . . 100 to 300 kvp. Half-value layers ranging from 0.25 mm Al to 4 mm Cu. Dose rate and half-value layer can be dialed right from control console: correct filter positions itself, kvp and ma are preselected *automatically!*



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MAXIMAR 100

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ISOTOPE TELETHERAPY

Select from seven cobalt and caesium units

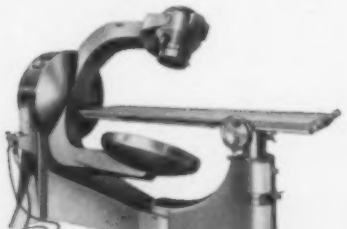
General Electric sells, installs *and services* a complete range of AECL isotope teletherapy equipment, capable of technics from conventional fixed-beam irradiation to complex rotational patterns. All have fail-safe shutters that close automatically in event of power failure.



THERATRON F (shown)—200 r/m/m maximum cobalt-60 source capacity. For fixed- and moving-beam teletherapy.

THERATRON B—165 r/m/m maximum cobalt-60 source capacity. Fixed- and moving-beam capabilities.

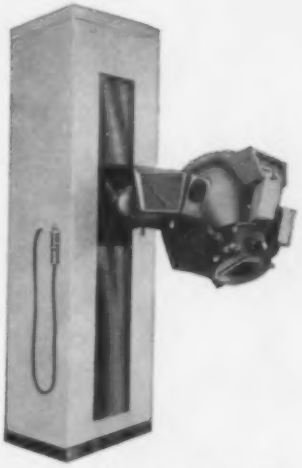
THERATRON C-II—50 r/m/m maximum cobalt-60 source capacity. For both fixed- and moving-beam technics.



THERATRON JR. (shown)—50 r/m/m maximum cobalt-60 source capacity. Fixed- and moving-beam teletherapy provisions.

Progress Is Our Most Important Product

GENERAL ELECTRIC



ELDORADO SUPER G (shown)—200 r/m/m maximum cobalt-60 source capacity. For fixed-beam teletherapy.

ELDORADO G—50 r/m/m maximum cobalt-60 source capacity. Fixed-beam teletherapy unit.



CAESATRON (shown)—1300-curie caesium-137 source capacity. Fixed-beam technic.

• *See your G-E x-ray representative for complete details on equipment for x-ray and isotope therapy. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room 1009.*

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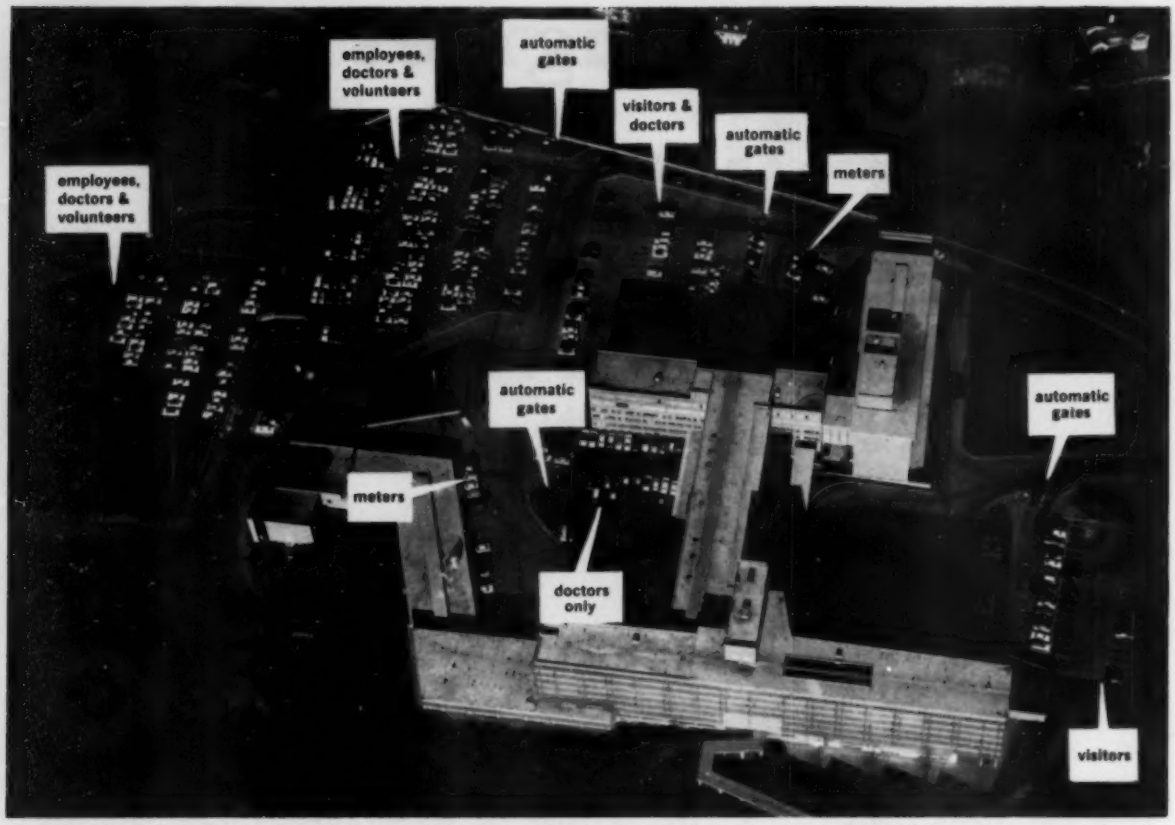


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Lankenau Hospital in suburban Philadelphia—one of the most modern hospitals in the country. "Controlled-Parking" provides ample parking all day long. Lots engineered, constructed, maintained, policed and operated by Auto Parks. No hospital care needed.

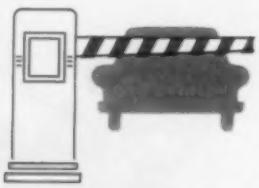
How AUTO PARKS' "CONTROLLED-PARKING" solved Lankenau Hospital's parking problem

When a physician complained an asthmatic patient had to walk 100 yards to the hospital's front door . . . and ambulances were sometimes blocked by visitors' cars . . . and hospital employees took choice parking spots, Lankenau Hospital knew it had a serious parking problem.

The hospital's Administrators and Board of Directors decided the best way to handle such a time-consuming, complaint-producing problem was to remove themselves from it completely. They decided to lease their lot to a specialist in "Controlled-Parking," *Auto Parks*.

At no cost whatsoever to Lankenau, *Auto Parks* constructed a completely new lot, altered existing lots and installed meters and fully-automatic gates. The lots are now policed daily by *Auto Parks*' personnel, and they need no attention from either Lankenau's maintenance crews or administrators.

Auto Parks can solve *your* present parking problem, or counsel you on what traffic loads you can expect in the coming years. Just clip, fill out and return the coupon below.



Automatic gates add and subtract cars as they enter and leave. When lot is full, traffic is routed to another lot. Traffic flow handled completely automatically.

Please send me more information about "Controlled-Parking"

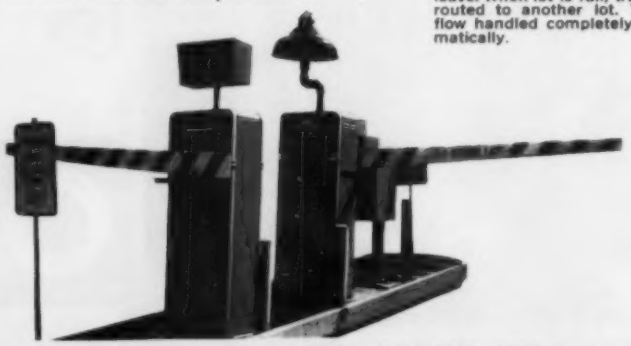
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HOSPITAL_____

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Auto Parks has been operating parking lots for the past 40 years. Other Auto Parks' "Controlled-Parking" subscribers include: The Pennsylvania, Baltimore & Ohio, Reading and Long Island Railroads.



AUTO PARKS, INC. DEVON, PA.



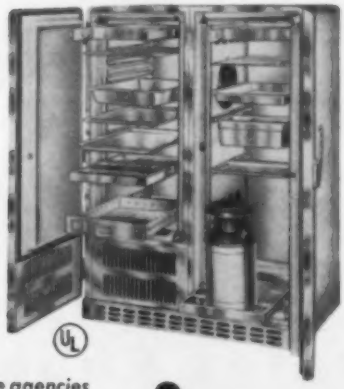
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For years, Victory refrigerators have been the *first choice* in the world's finest kitchens. And there's good reason, too! As a radical innovation we pioneered and produced the first all-metal refrigerators. We then created, patented, and made available the *first* interchangeable interiors which could be changed or rearranged in minutes — without tools. Today Vimco®, Sta-Kold®, Sno-Queen® refrigerators continue to be first with the foremost features. *That is why more and more experienced buyers are demanding Victory refrigerators . . . first of all!*



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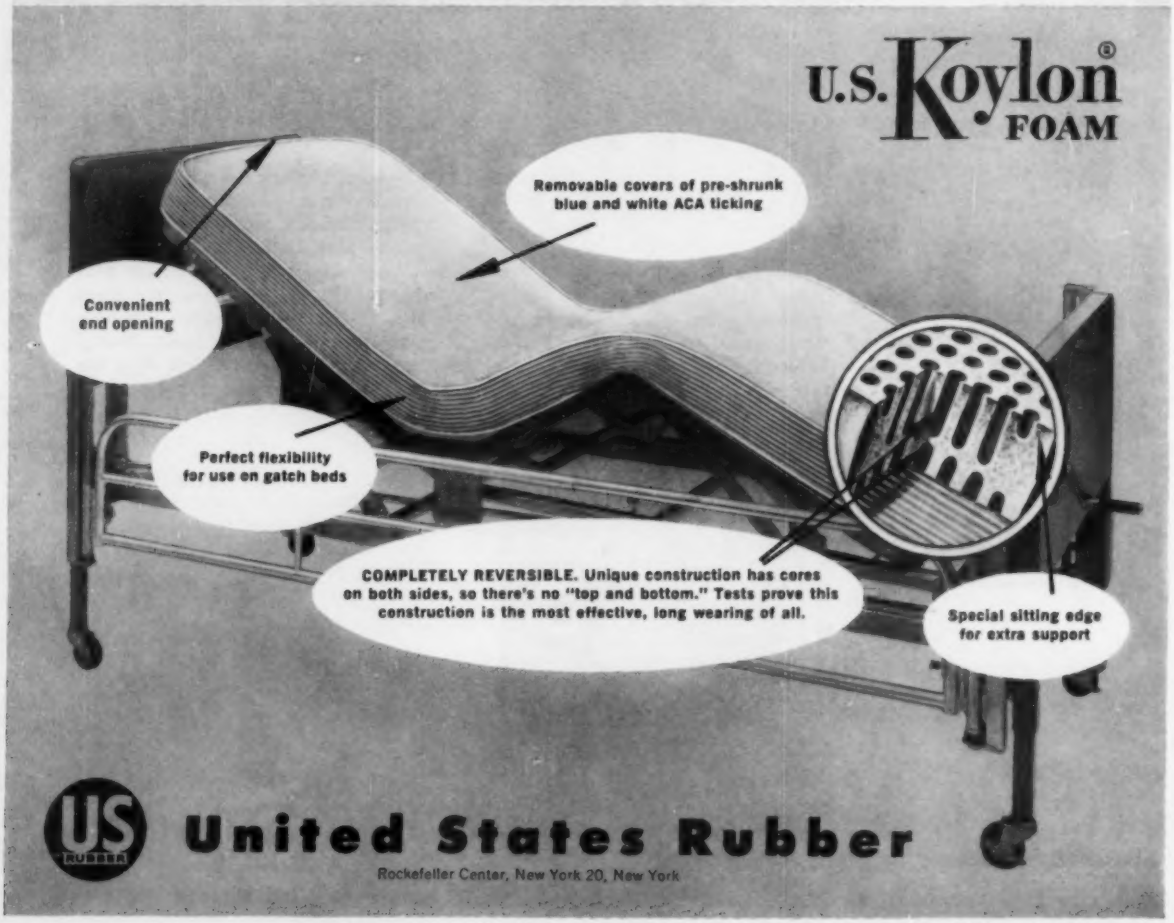
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No two foams are the same... any more than two medicines are



U.S. Koylon foam mattress is in a class by itself

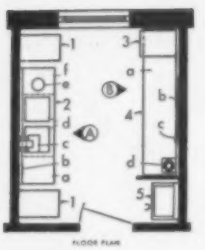
The chemicals in foam must be measured as accurately as those in a drug. (Did you know that a ½% variation in one chemical can mean a difference in years of mattress wear?) U.S. Koylon foam is not only compounded, but especially engineered, to meet hospital standards. It is the only mattress—foam or conventional—with all these advantages: **Gives ideal support and comfort to the patient.** Koylon's unique double coring adjusts to the body's pressure points, reduces danger of bed sores. It is self-ventilating, cool in summer. **Gives you no maintenance problems.** Has no mechanical parts to break down or rust; no padding to pack or lump. Is verminproof. Takes autoclaving.

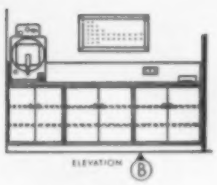


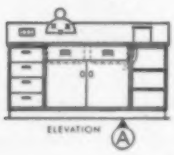
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a low cost practical technic for the small INFANT-FORMULA ROOM









The Amsco electric heat Model 832 Formula Sterilizer enables hospitals with one to eight bassinets to carry out advanced techniques formerly possible only with large capacity equipment costing much more. Its capacity of 32 four or eight ounce bottles is ample to serve eight bassinets, using two cycles per day. The Model 832 requires minimum attention from the operator because complete cycling is automatic and forgetproof according to the time, temperature and exhaust settings selected.

Permits a Modern Formula Room in the minimum area.

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For complete information on the small Infant Formula Room, write for bulletin SC-319. (Hospitals with larger nurseries should request brochure SC-320R.)

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SAVE TIME AND CASH

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By providing the *right* tool for every floor cleaning operation, White equipment saves costly man-hours and helps maintain brighter, cleaner floors. 252 specialized, rugged, long-lasting items (developed through 65 years of successful experience!) are the reasons why more White tools are in use today than *all other brands put together!*

FREE CATALOG

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PHOTO: Tymsaver Mopping Outfit combines powerful "Can't Splash" Wringer with White heavy duty oval bucket. Assures a cleaner, dryer mop after each squeeze, for economical, efficient cleaning.

SKETCH A: **Downward Pressure Wringer; new splash pad makes wringer mechanically sound, trouble-free for years.**

SKETCH B: **"Can't Splash" Wringer; 16-to-1 leverage squeezes large mops dry with little more effort than it takes to shift gears in a car!**

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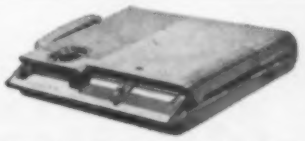
Edison Voicewriter helps him get records "down on paper" at once

POST-OPERATIVE REPORTS, consultation notes, all types of medical records are completed faster . . . more easily . . . when Edison Voicewriter dictating phones are available at strategic locations throughout the hospital.

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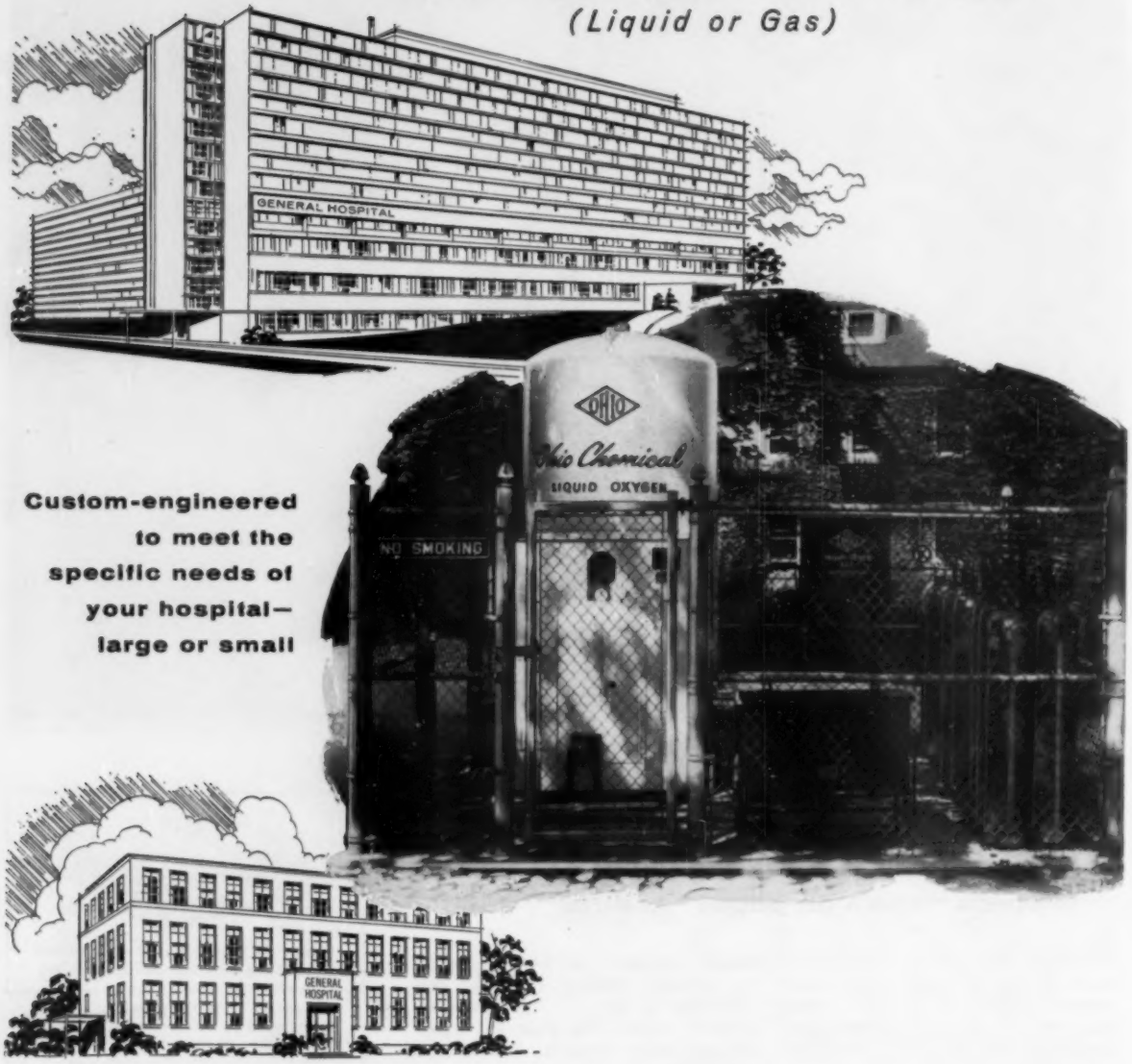
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Above is the Zenith Monaco, Model E2010C, available in Westpoint gray with white trim.* Pillow and earphone speakers for private listening, specially designed roll-about stand, available at extra cost.

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Progress Report on Autoclave Wrapping

...based on questions asked about DennisonWraps by OR Supervisors at the 1960 AORN Convention.



Q. *What outstanding reason do hospitals give for replacing muslin and other autoclave wrappers with DennisonWraps?*

A. Many hospital authorities are convinced that DennisonWraps are safer to use than other wrapping materials. Large hospitals are also attracted by the lower cost per use and the elimination of laundry bottlenecks. Smaller hospitals list space savings and faster drying as additional factors.

Q. *What evidence is there that DennisonWraps satisfy all sterility requirements?*

A. Published reports of clinical tests, available on request, establish that:

1. For standard wrapping procedures DennisonWraps are significantly superior to muslin in terms of time required to reach a given temperature.
2. DennisonWraps will maintain sterile conditions at 35°C, 24°C and 4°C for varying lengths of time up to 6 weeks.
3. Bacteriological tests performed on DennisonWraps which had been used 10 times produced negative results consistently.

Since 1957, numerous hospitals have confirmed the accuracy of these statements.



Q. *What must be done to assure the return of DennisonWraps to Central Service for reuse?*

A. Nothing! All DennisonWraps—pre-cut sheets, tubing, glove envelopes and cases—carry the hygienic imprint: "Reusable DennisonWraps . . . return to Central Service." This constant reminder guarantees maximum reuse and lowest cost per use.

Q. *What is the basis of the claim that DennisonWraps have a lower cost per use than muslin?*

A. A comprehensive hospital study conducted by Mrs. Jean E. Christie, R.N., as reported in HOSPITAL TOPICS, March-April, 1957, established these facts:

Size of Wrap	Muslin Cost per use @ 50 uses	DennisonWraps Cost per use @ 6 uses	DennisonWraps Cost per use @ 1 use
15″ x 15″	.02251	.01027	.02189
30″ x 30″	.05335	.01757	.05740
40″ x 40″	—	.02846	.09049
45″ x 45″	.09697	—	—

Q. *Does the use of DennisonWraps involve any change in wrapping techniques?*

A. No! Because DennisonWraps are made of double-creped paper with two-way stretch, they have folding and shape-conforming properties similar to muslin. Moreover, since they lack the bulk and floppiness of muslin, hospitals report that it is much easier to train new personnel to wrap with DennisonWraps.

Q. *What's the first step in making the transition to DennisonWraps?*

A. Write for a free hospital evaluation kit. It contains test quantities of DennisonWraps in precut sheets, glove wicks, envelopes and cases, 3″ tubing, *plus* three clinical reports which prove that DennisonWraps will increase the safety, efficiency and economy of your autoclaving operations. Address your request to Dennison Manufacturing Co., Dept. F-9, Framingham, Mass.

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for superior autoclaving
at lower cost



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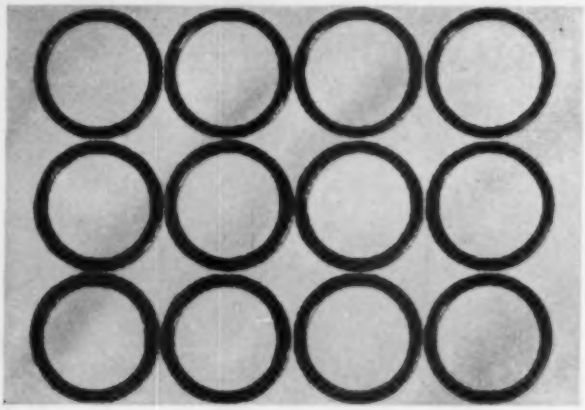
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REGULATED VACUUM. The NCG Suction Bottle Unit provides for regulated drainage of the oral cavity, trachea, etc. Vacuum level is maintained by the vacuum regulator between 0 and 200 mm of mercury. For special application of high vacuum by surgeons, suction units without regulator are available.

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Here are *answers* to some frequent *questions* about conductive floors for operating room safety

Q. ***What makes a Conductive Floor electrically conductive?***

A. In general, conductivity is accomplished by the presence of special "conductor agents" in the floor material. Carbon is a popular "conductor" in some floor materials. With terrazzo and magnesite, the "conductor" is incorporated in the binder.

Composition type floor coverings are usually laid over a grid of thin copper strips which is connected to a ground.

Q. ***Are Conductive Floors required by law?***

A. Hospitals receiving construction grants under Public Law No. 725 must install Conductive Floors. Under this law, the Public Health Service specifies minimum allowable areas of Conductive Floor in delivery rooms, major and minor operating rooms, etc.

As the result of a number of fatal operating room explosions, state fire marshals and other interested government officers, as well as national fire protective underwriters, all encourage conductive floors and equipment in hospital operating rooms.

Q. ***What is the best source of recommendations and suggested specifications for Conductive Floors?***

A. The National Board of Fire Underwriter's booklet, (N.B.F.U. No. 56), gives "RECOMMENDED SAFE PRACTICES FOR HOSPITAL OPERATING ROOMS." It is the most comprehensive data published on this subject.

Q. ***Can a Conductive Floor loose its conductivity?***

A. Yes, particularly conductive floors of terrazzo and magnesite where continued mopping and scrubbing "bleed away" the conductor agents.

Q. ***Does regular mopping and scrubbing have any other bad effects on a Conductive Floor?***

A. "Bleeding away" of the soft conductor agents tends to make the floor porous —leaving pits which are ideal breeding places for bacteria.

Q. ***Can this loss of conductivity and tendency to "pit" be halted?***

A. Yes.

Q. ***How?***

A. By using Holcomb Conductive Floor Wax.

Q. ***What is Holcomb Conductive Floor Wax?***

A. It is a liquid water-emulsion floor wax, developed by Holcomb from nine years of research and testing on all types of Conductive Floors under a variety of severe usages. *It contains a special conductor ingredient which makes the wax electrically conductive.*

Q. ***What protection does this wax give the floor?***

A. Holcomb Conductive Floor Wax provides a tough, durable surface film which is highly water resistant and capable of withstanding the repeated cleaning which operating room floors get. It seals in the floor's natural conductivity—fills any pores—gives the floors a velvety, long-lasting, slip-resistant fully conductive sheen.

Q. ***What other advantages are there in using Holcomb Conductive Floor Wax?***

A. This wax makes the maintenance of the conductive floor far easier, less time consuming and much less costly. It keeps operating room "spillage" on top of the tough wax film where it is easy to mop up . . . prevents such "spillage" from seeping down into the pores of the floor where it is difficult and time-consuming to scrub out.

Q. ***Can Holcomb back up all these claims?***

A. Holcomb Conductive Floor Wax has been subjected by the Underwriters Laboratories to a variety of severe tests included washing with detergent, exposure to common antiseptics and protracted exposure to low relative humidity.

As a result of these tests the Underwriters Laboratories says, "*The wax does not adversely affect the resistance of the electrically conductive flooring and therefore conforms to the recommended safe practice of the N.B.F.U. for hospital operating rooms.*"

On the subject of *stability*, the report states, "The floor wax . . . is judged unlikely in service to undergo changes resulting in increases of overall electrical resistance which would prevent dissipation of electrostatic changes . . . "

". . . has a slip-resistance characteristic greater than the minimum acceptable value."

Q. ***How is Holcomb Conductive Floor Wax applied?***

A. Like any water-emulsion wax—in thin coats with a chenille or sheep's wool applicator or a short strand cotton mop.

Q. ***Will an excess of the wax reduce the conductivity of the floor?***

A. While this is a possibility, the Holcomb Research Laboratory and the Underwriters Laboratories have been unable to detect any change in the conductivity of a floor that is protected by this wax. However, with good floor maintenance procedure excessive thickness will not occur.

Q. ***Will Holcomb Conductive Floor Wax make a non-conductive floor into a conductive floor?***

A. No.

Q. ***What is the most effective way to clean a floor waxed with Holcomb Conductive Floor Wax?***

A. With Holcomb CHEMAGIC, a synthetic detergent approved by Underwriters Laboratories as a safe cleaner for Conductive Floors. A stronger solution of CHEMAGIC is recommended for "stripping" the wax from the floor.

Q. ***How can a hospital obtain an actual demonstration of the effectiveness of the wax on its own Conductive Floors?***

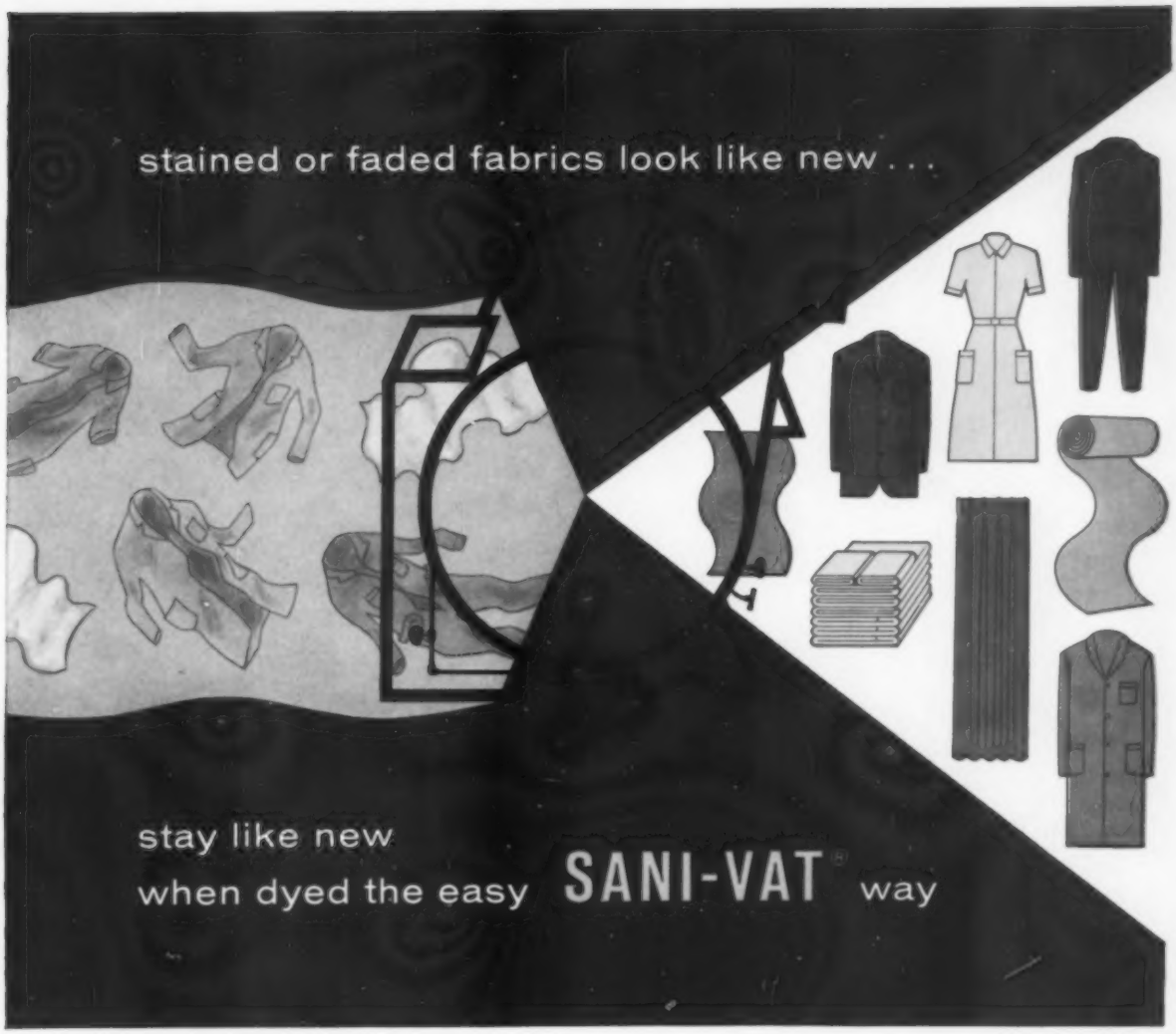
A. By asking the Holcombman in your area whose name we will be happy to furnish you upon request.

Q. ***When would be a good time for such a demonstration?***

A. The sooner the better.

Holcomb Conductive Floor Wax is one of more than 300 Scientific Cleaning Materials from the Holcomb Research Laboratory designed to reduce the cost, labor and drudgery of building maintenance. Let your nearby Holcombman show you how many of these products can be of special help to you.

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...some of the new pipets we've added during the past year or so

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New tips. There's a bigger hole in the tip of No. 7087 that lets you work faster with viscous liquids such as heavy creams, curds, and oils. Thanks to an extra-long, narrower tip on No. 7084, you can work more easily with Warburgs, small flasks and tubes, and the like. Tips on No. 7105 pipets, designed especially for Folin tests of urine and blood sera, are now uniform in length and diameter.

Like all PYREX tips these are stoned to a smooth bevel which reduces snagging and breakage significantly.

New tops. No. 7086 is an ACCU-RED pipet with a cotton plug top for safe transfer of a virus or pathogen; for the first time you can combine the strength and long-lasting marks of ACCU-RED with cotton plugs.

No. 7096 is a rinse-out pipet for accurate micro dilutions.

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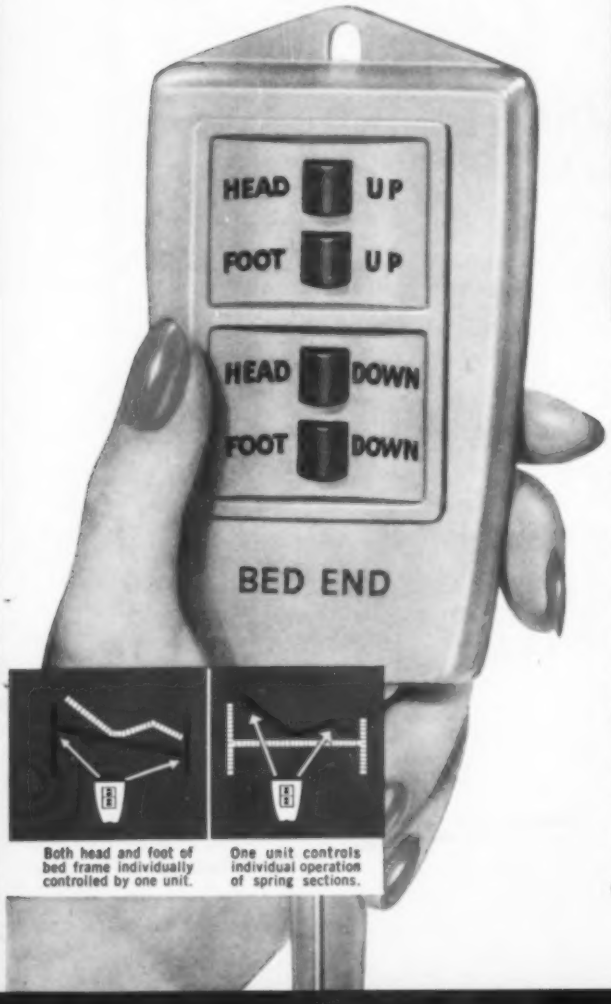
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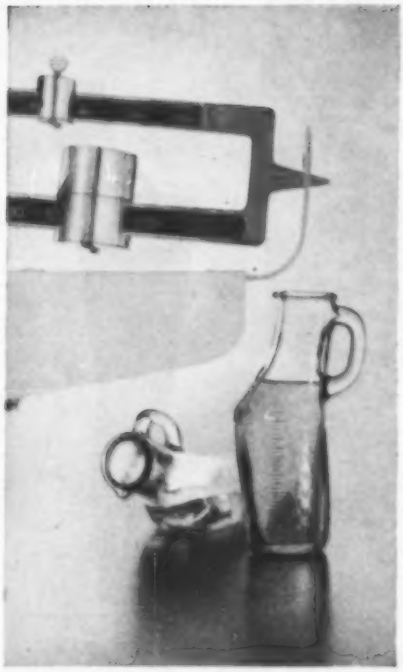
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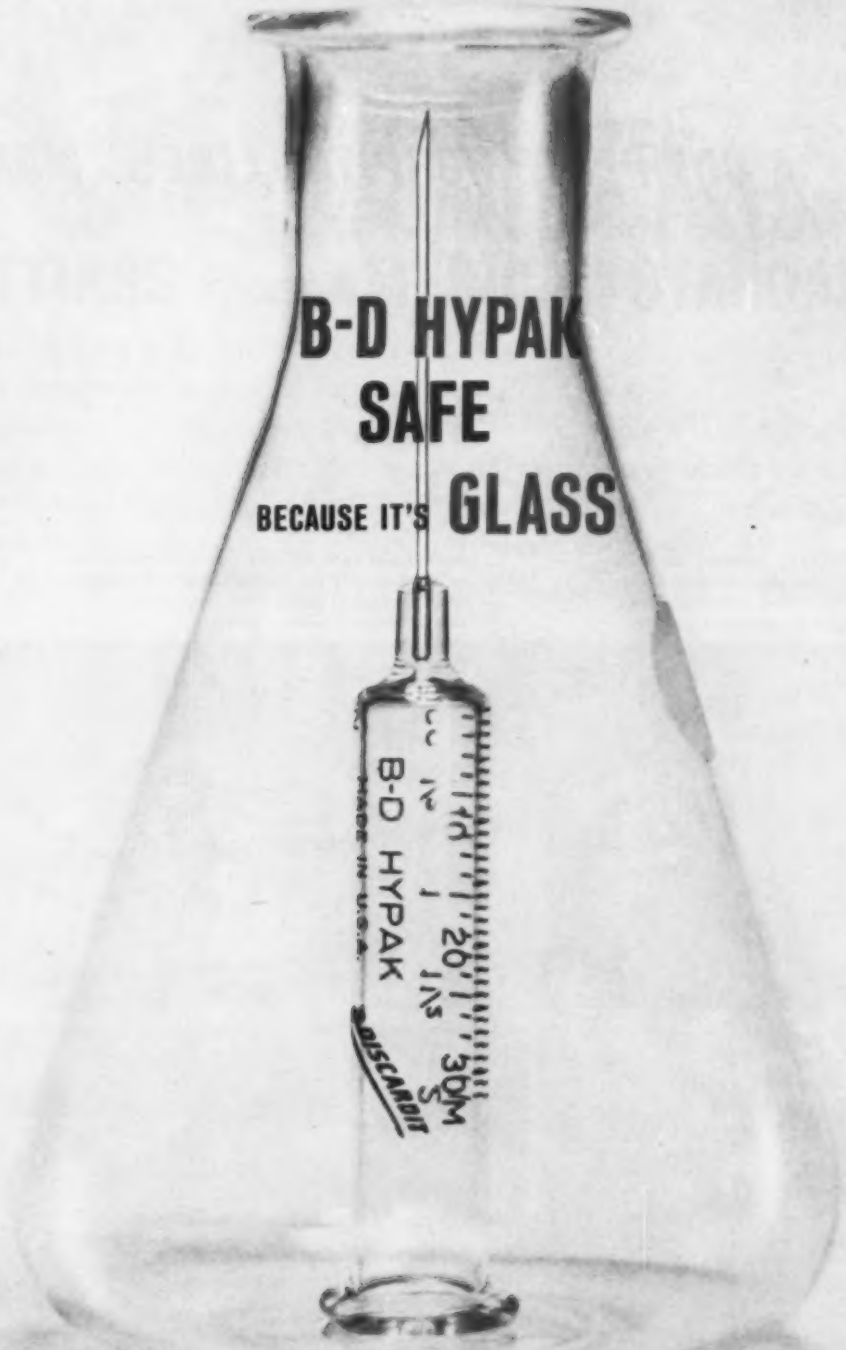
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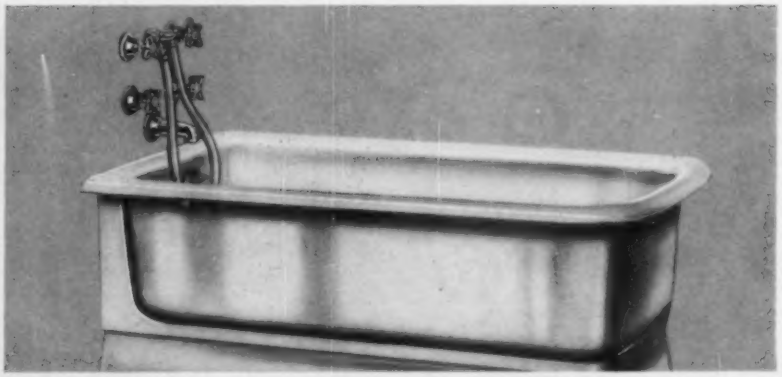
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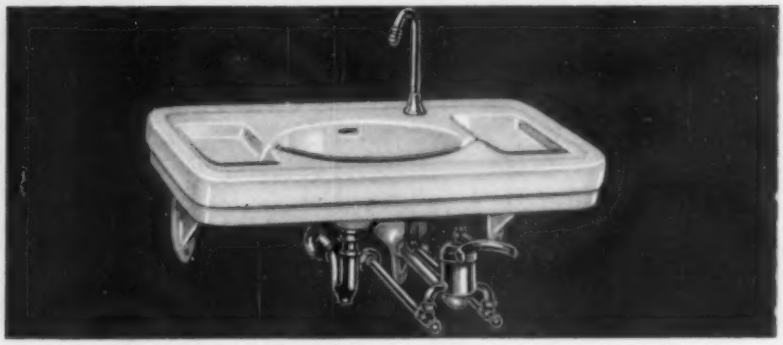


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AN IMPORTANT STATEMENT ON BACTERIAL SENSITIVITY TESTING WITH THE NITROFURANS

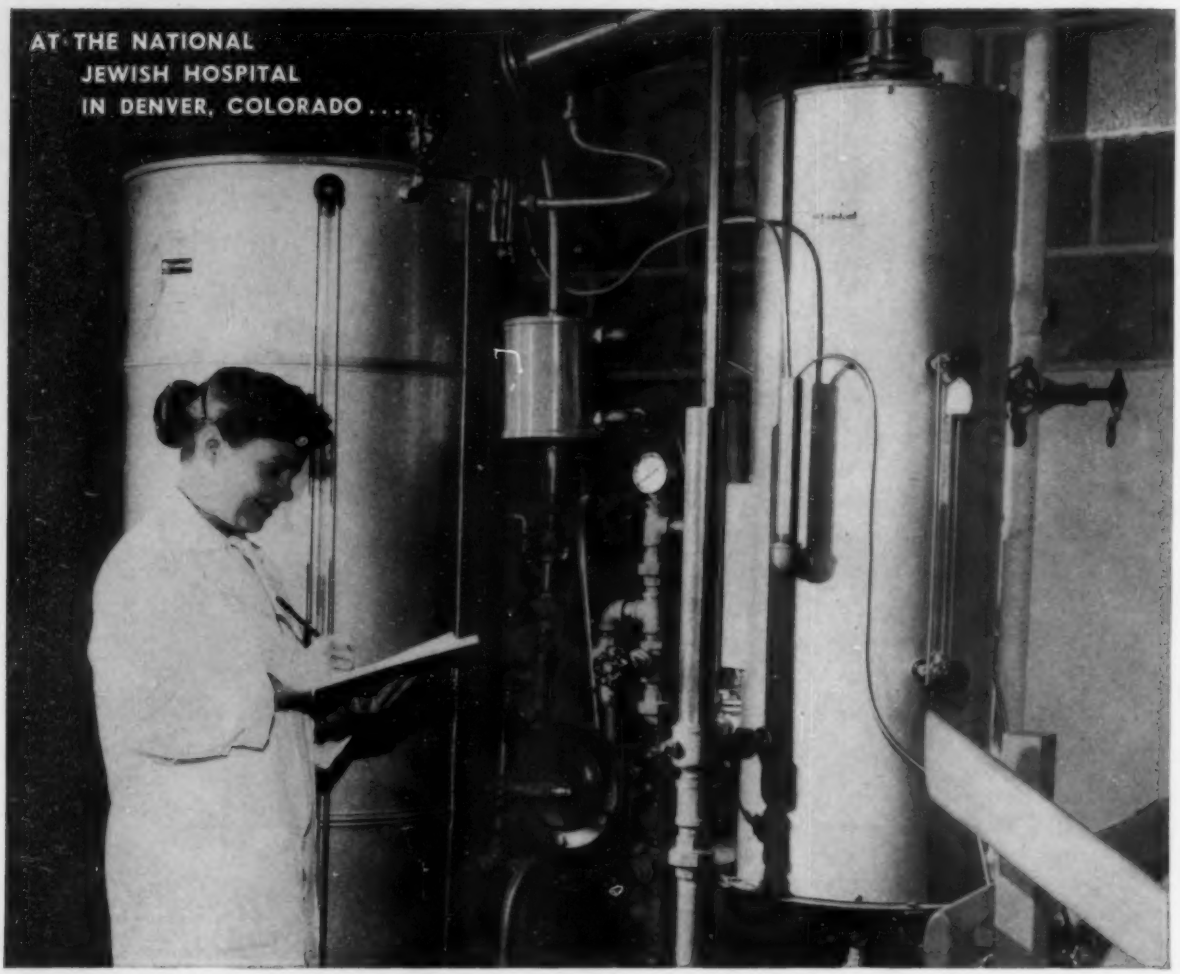
The individual nitrofurans – ALTAFUR, FURADANTIN, FUROXONE, FURACIN—*are not interchangeable either in clinical application or in susceptibility testing.* Although chemically related, these compounds differ to a highly significant degree in their range of antibacterial activity as well as in solubility, diffusion rate, and other physical characteristics. For this reason, SENSI-DISCS* containing each of these nitrofurans are provided for appropriate disc plate testing. *Results are valid only for the compound tested.* Cross-interpretation will lead to erroneous conclusions.



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FUROXONE® (brand of furazolidone)	Wide. Especially effective against enteric pathogens.	Enteric infections. (Minimal systemic absorption.)	FUROXONE SENSI-DISCS*
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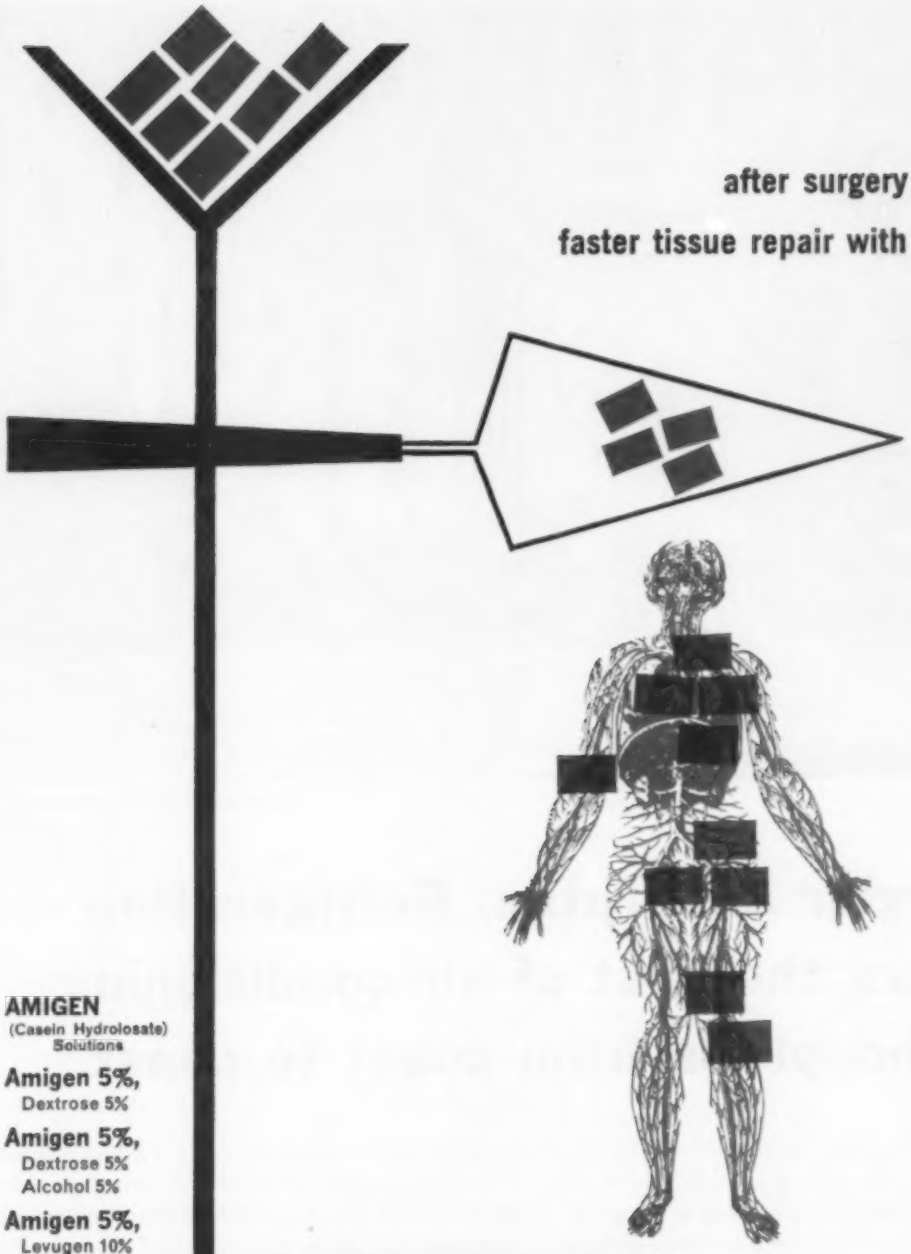
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Lakeland General Hospital	*Lakeland, Florida*
Northeast Florida State Hospital	*MacClenny, Florida*
Jackson Memorial Hospital	*Miami, Florida*
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Argonne Cancer Research Hospital	*Chicago, Illinois*
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Resurrection Hospital	*Chicago, Illinois*
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Great Lakes Naval Hospital	*Great Lakes, Illinois*
Our Savior Hospital	*Jacksonville, Illinois*
West Suburban Hospital	*Oak Park, Illinois*
Proctor Community Hospital	*Peoria, Illinois*
Memorial Hospital	*Springfield, Illinois*
St. Catherine Hospital	*East Chicago, Indiana*
Protestant Deaconess Hospital	*Evansville, Indiana*
Community Hospital	*Indianapolis, Indiana*
Associated Physicians & Surgeons Clinic	*Terre Haute, Indiana*
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St. Mary's Hospital	*Rochester, Minnesota*
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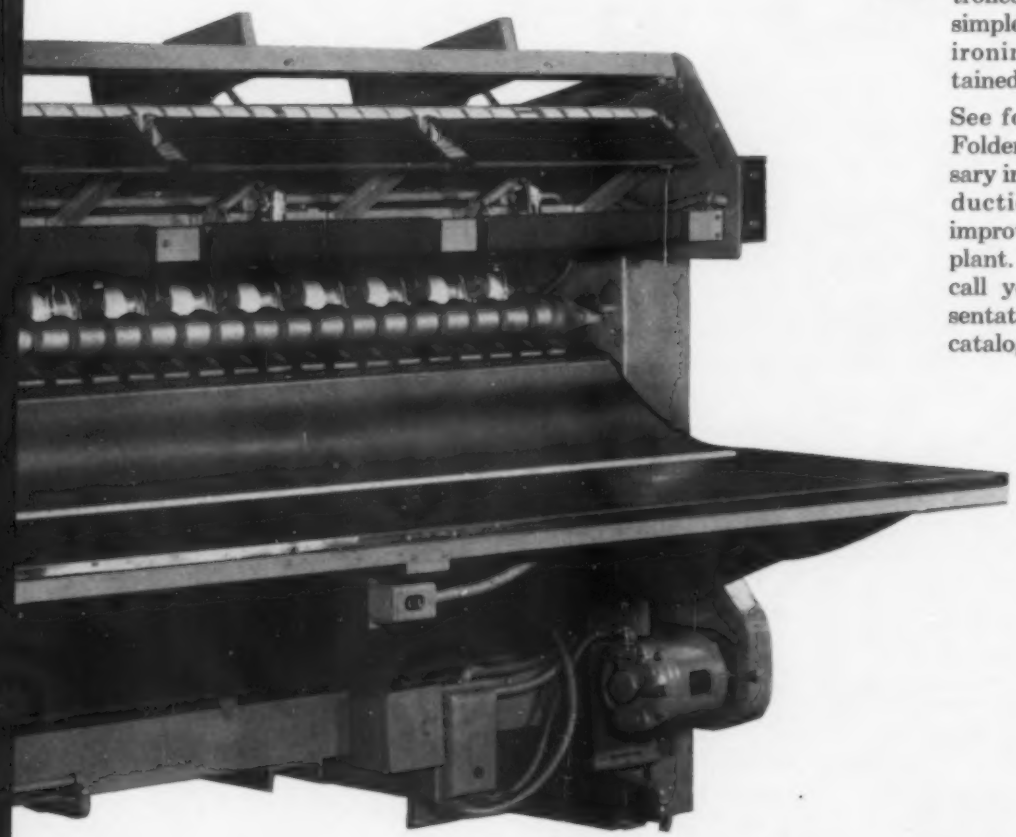
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SMALL HOSPITAL QUESTIONS

When To Postdate Bundles

Question: We have recently adopted the practice of resterilizing all goods that have been sent out from central supply every 30 days. To this we have added the procedure of postdating (that is, dating each bundle 30 days from the date of sterilization) each bundle prior to putting it into the sterilizer.

What is the recommended practice for stamping the date on bundles: (1) prior to sterilization, or (2) after sterilization? — J.A.E., Vt.

ANSWER: We referred your inquiry to Frances Ginsberg, R.N., our consultant in aseptic practice. Her reply follows:

"First, I believe that a 30 day period is an optimum time for resterilization of goods, providing the goods have been adequately wrapped and sterilized in the first place. With good organization and rotation of supplies used throughout the hospital, there should be few articles that demand resterilization.

"I feel keenly that goods should be dated after sterilization rather than prior to sterilization. In this fashion there is little opportunity for error."

Where To Store Ice Scoops?

Question: We would like to enlist your assistance in solving a hospital sanitation problem which is very prevalent, at least in this state.

The problem concerns the storage of scoops used to dispense ice for drinking water. Frequently we find that the scoops are stored within the ice in the ice chests. Where this is done transfer of contamination to the ice from the handle of the scoop or from a person retrieving the scoop is extremely possible.

Storage of the scoop outside the ice chest is satisfactory, provided, however, it does not come in contact with an unclean surface and it can be protected from airborne contamination. The moisture on the scoop creates an additional problem of obtaining proper drainage. Where there is no provision for drainage, constant maintenance is necessary to keep dry conditions.

As far as we know there is no container manufactured which would be satisfactory for storage of ice scoops either inside or outside of ice chests. Such a container would have to meet the following requirements:

1. It must be constructed of corrosion resistant material such as stainless steel or heavy duty plastic.

2. It must be of such shape so as to be easy to clean and to provide for drainage.

3. It must be large enough to handle any size of ice scoop in common use.

4. It must have an adequate cover, easily removable, but yet not loose when in place.

5. It must be constructed so that it can be fastened to the ice chest or hung in a near-by location, yet remain detachable so that it can be readily removed for cleaning and, if necessary, disinfecting.

6. It must have a drain hole, or other opening, in the bottom to allow for the elimination of water which runs off the scoop. Perhaps a port hole with a short nipple could be provided in the bottom, which could be connected by tubing to the ice chest drain line.

If you know of any such product already manufactured we would be pleased if you would inform us about it. If not, could you assist in promoting the need for this item so that some manufacturing firm might initiate the manufacture of it? — R.G.N., Mich.

ANSWER: We are not sure there is any product that meets the specifications outlined in your letter. We referred your query to an authority on this subject who concurred with this view, as indicated by his letter, which follows:

"I know of no device to disinfect ice scoops. Ice tongs can be stored in a simple jar containing one of the quaternary germicides. Modern ice makers are now provided with dispensing funnels where gravity serves to direct the cubes or chips into a container, obviating the use of scoops."

What Unemployment Compensation Costs

Question: Have any states reported the experience of private nonprofit hospitals under an unemployment compensation law? If so, what has been the contribution rate for such coverage as compared to the benefits paid? — R.V., Iowa.

ANSWER: One of the few states in which this law covering hospitals has been in effect long enough to provide meaningful statistics is Hawaii, which recently reported claims experience of such hospitals.

The Hospital Association of Hawaii and the Hawaii Bureau of Employment Security have made available the following aggregate figures:

Despite the fact that the contribution rate decreased steadily, the annual contributions ranged from 3.6 to 7.9 times the amount of benefits paid.

Seven hospitals reported their claims experience under the law. For the last three years the figures are: 1954, claims filed, 46, claims paid, 37; 1958, filed, 65, paid, 42; 1959, filed, 48, paid, 38.

Five hospitals that reported cost per patient day attributable to unemployment contributions gave figures ranging from 2 cents to 23 cents, but the average was 10.5 cents for the last three years.

Year	Number of Hospitals Covered	Average Contribution Rate	Total Contribution	Total Benefits Paid
1954	13	0.54	$31,870.45	$7,122.73
1955	14	0.53	30,027.01	5,136.91
1956	14	0.40	23,700.82	6,615.59
1957	15	0.411	25,213.48	3,196.22
1958	15	0.393	26,717.76	5,946.61

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wire from Washington

CARE OF AGED STILL KEY ISSUE

The question of a medical care plan for the aged continues to be the most controversial domestic issue before Congress. At this writing the House ways and means committee is meeting daily on the subject, but if it is near a decision no word of this fact has leaked out.

There is hardly a Congressional Record – the daily newspaper of Congress – that does not contain from one to half a dozen articles on medical care for the aged, inserted by senators and representatives. Outside Congress, the leaders on both sides of the issue – the A.F.L.-C.I.O. for the Forand bill, the American Medical Association against – are exchanging broadsides.

Also, two top aspirants for the Democratic presidential nomination, Senators John Kennedy and Stuart Symington, plug for the Forand idea in virtually all their talks.

Yet, the choice remains just what it has been for 10 years: a hospitalization-medical care program supported through social security, or a U.S.-state plan supported by general taxation.

The long-delayed Eisenhower-Flemming plan is the most prominently mentioned of the latter, nonsocial security proposals. It had hardly been introduced, however, when the ways and means committee gave it virtually a flat turndown – "it would cost too much money."

Although it was doomed even before it was put down on paper, the Eisenhower-Flemming program for the aged is remarkable in at least one respect – it actually would do more for the old people than the only social security plans being seriously considered by the Democrats.

In drawing up his program, the H.E.W. Secretary had to follow three main guidelines laid down by the Administration when it rejected his social security approach:

1. It could have no connection with the social security system and it could not be compulsory.

2. It would have to make the states partners, so the federal government wouldn't be putting up all the money.

3. It would have to stimulate voluntary health insurance companies and associations, not drive them out of the field of protection for the aged.

Here are the Flemming plan's major provisions:

State and Federal Contributions. The U.S. would put up about $600,000 per year, to be matched by a like total from the states. Funds would be allocated among states on a formula similar to that used for the Hill-Burton hospital construction program: U.S. to pay two-thirds of the cost for the lowest income states, one-third for the highest income states, with graduated schedules for the others.

Premium and Eligibility. Persons 65 years of age and older would be eligible to participate if they do not pay federal income taxes or if their individual incomes do not exceed $2500 per year ($3800 for a couple). The cost to participants would be $24 each per year; coverage would be given welfare recipients without charge.

Deductibles. The first $250 per year of medical care costs would have to be paid by the individuals ($400 for a couple), with the U.S.-state funds paying 80 per cent of the remainder. All bills of welfare patients would be paid.

Benefits. The program would pay for up to 180 days per year of hospital care, full nursing home care, and organized home care services; surgery, laboratory and x-ray costs up to $200 per year; physicians' and dentists' bills, up to $350 annually in prescription drugs, private nurse services and physical rehabilitation costs. If an aged person preferred, he could forego these benefits and instead purchase from a private group a major medical expense insurance policy, for which he would pay half the cost up to $60 per year, with the U.S.-state funds paying the other half.

Continuation of Eligibility. If a person qualified for coverage because of low income, then found his income increasing, his premium would increase gradually until the point was reached where he was not being subsidized out of the U.S.-state funds.

Administration. The program would be administered by the states, but their plans would have to be approved by the Department of Health, Education, and Welfare.

SENATE INVESTIGATES FORMULARIES

Hospital formularies – their advantages, disadvantages, their possible risks – now have become an issue in the drug price hearings being conducted by Chairman Estes Kefauver's Senate subcommittee. The investigation is slowing down for the closing weeks of the session and the political conventions, but the subcommittee plans to resume it full force in August.

The issue of formularies more or less slipped in the side door, but now it's a permanent part of the record and can't be dropped.

At hearings on brand name *versus* generic name drugs, the subcommittee used the hospital formulary as evidence that a large amount of money can be saved, and good medical care preserved, if doctors are required to prescribe by generic names.

It is the subcommittee's feeling that owners of patents on prescription drugs overprice these products, and spend too much money promoting them to the doctors. Some subcommittee members are considering legislation that would require doctors to use generic names instead of the advertised trade names, so the prescription could be filled from a cheaper drug of the same basic chemical. It is their contention that this in itself would end high prices and expensive promotion, because the market would go to less expensive drugs.

This subcommittee view has been contested by industry

witnesses on two main points. Their arguments are:

1. Without a substantial profit margin on patented drugs, manufacturers couldn't have the money to spend on extensive research that produces new drugs and careful control measures in the processing that protect patients.

2. Doctors should continue to have the assurance their patients will be given exactly what is prescribed, not something a pharmacist thinks is "like it." Industry spokesmen, as well as some pharmaceutical school deans and medical researchers, have testified that variations among brands provide important choices in the treatment of patients. For example, one manufacturer's reserpine might be acceptable for one patient, but a source of trouble for another.

A key witness for the subcommittee on this point was Dr. August H. Groeschel, associate director of professional services of the New York Hospital and assistant professor at Cornell Medical College.

Dr. Groeschel first described how a hospital formulary is organized and how it operates. In the case of his hospital, it is under complete medical control and works in close association with specialists on Cornell's staff. He said there is no risk in the mandatory use of generic name drugs because the manufacturers are known and the products are tested in the hospital and medical school.

This hospital's chief pharmacist has estimated that use of generic drugs saves the institution a quarter of a million dollars annually, compared with the cost of trade name products. Doctors are required to use generic name prescriptions for ward and charity patients, but may use trade names for private patients, with the patients paying extra.

Dr. Groeschel is encouraged because the American Hospital Association is attempting to standardize formularies, a development that to him is something like nationwide approval of generic-drugs-only for hospitals.

A part of Dr. Groeschel's testimony was a denunciation of the National Pharmaceutical Council, formed by a number of drug manufacturing houses. He described this body as "rich, powerful and aggressive."

Under questioning, Dr. Groeschel admitted that a physician practicing "out on his own" might have more reason to rely on company-backed trade name drugs than would a doctor practicing at a large hospital with medical school affiliations, where he could assume any drug carried in the formulary was reliable.

Subsequent witnesses also pointed out that the big, medical college-affiliated hospitals are the exception. If these hospitals want to set up formularies and require generic names on prescriptions, the hospitals are equipped to test and evaluate all drugs. Most smaller hospitals can't provide this service, the witnesses pointed out, and for that reason they wouldn't recommend generic-drugs-only for all hospitals.

Also of importance in the hospital formulary issue is the testimony of Dr. Newell Stewart, executive vice president of the National Pharmaceutical Council, which, according to Dr. Groeschel, is determined to wipe out hospital formularies.

Dr. Stewart was a very direct witness, who admitted at the outset that the council's primary purpose is to bring about state legislation outlawing substitution of drugs at the discretion of the pharmacist. He also said flatly that the council believes hospital formularies should not have the right to restrict doctors' prescriptions in any way — if they order a drug, that's what the patient should have, whether he's a welfare or a private patient.

On the issue of hospital formularies, Dr. Stewart said: "A voluntary formulary which does not restrict the prescribing habits of a physician is proper. We feel that every formulary should state clearly how a physician is to obtain for his patients any drug not listed in the formulary."

Dr. Stewart didn't apologize for activities of the council, said it was still active and "successful," and that it was moving right ahead. An indication of the council's motivation, as expressed by Dr. Stewart: "Wherever drug dispensing practices in hospitals show improper consideration for the public, the physician or the pharmaceutical industry, the council will bring such practices to the attention of hospital pharmacists and hospitals."

There was some discussion as to whether the council was threatening hospital pharmacists with loss of their licenses if they participated in generic-name-only formularies. Nothing definite was established on this point, but Dr. Stewart at no time receded from his position: Unless the hospital itself is in a position to guarantee drugs supplied under generic name, the practice is dangerous.

The touchy question of whether hospital formularies tend to charge trade name prices for generic name drugs came up only once, in the reference of one witness to the fact that "hospital pharmacy departments are one of the few hospital departments that are money-making." He did not go into detail.

One big question now is whether the hearings, assuming they go more deeply into hospital pharmacy, will establish that it is wise or risky for hospitals not connected with medical schools to demand that doctors accept the cheaper generic name drugs when they are available.

(For more information on drug hearings, see page 88.)

START REGIONAL RESEARCH PROJECT

Eight medical schools and their hospitals are embarked on a new type of research project. Using grants from the National Institutes of Health, they are in the process of setting up regional clinical research centers.

The new facilities, according to Public Health Service, "will provide a new type of resource permitting intensive controlled study of a limited number of patients as part of the clinical research activity of the institutions receiving the grants."

If the regional centers prove valuable, the credit must go to Congress, not N.I.H. In clearing this year's appropriations, Congress instructed N.I.H. to try out the new plan, and provided $3 million for financing.

The grants will pay for renovation and equipping of facilities, and later will pay all their expenses, including salaries of professional staffs. Participating schools of medicine are University of Southern California at Los Angeles, Emory and Johns Hopkins, Michigan, Washington at St. Louis, New York-Bellevue, Pennsylvania and Washington at Seattle.

The Modern Hospital
JUNE 1960



LOOKING AROUND

Another Thing

LOOKING around the business press not long ago in our continuing search for intelligence to pass along to hospital readers, we came across this piece on personnel and, especially, the quality of supervisory and department head performance — a timely subject, according to our reading of the hospital temperature chart. Judging the performance of department heads is an important administrative responsibility, the author said — not unreasonably, we thought.

The factors of primary importance to be considered in evaluating department head performance were then listed. These were: (1) developing the potential of all employes; (2) delegation of responsibility and authority; (3) identifying and solving problems; (4) training one or more employes as successors, and (5) quality of on-the-job training and employe relations.

No doubt about it, those things all count, and a good department head should have a high score as a potential-developer, authority-delegator and employe-trainer. But something was missing, it seemed to us, and after giving the matter some thought we decided there was another thing we'd expect *our* department heads to do reasonably well:

Run their departments.

Grandpa's Overalls

AT A time of revolutions, summit snubbing, moon-shots, sit-in demonstrations and the most serious public discussion of the place of religion in national life that has occurred in 32 years, medical care of the aged has become one of the hottest political issues of the year. How did it happen? The aged aren't any sicker, or much older, than they have been in other years, when nobody thought much about their health one way or the other. There are a few more of them around every year, to be sure, but this has been going on right along and can scarcely be considered a newly discovered menace, like strontium in milk. So how did Grandma's hospital bill get to be as big, politically if not fiscally, as the national debt?

Some students of the subject believe the political importance of medical care of the aged has outrun its substantive importance because the issue is somehow peculiarly adaptable to the antic behavior of Americans in a presidential year, when a show of noisy disagreement is mandatory. Until the spy-plane incident came along last month, no other issue seemed to fit the demand of the time so neatly, and so safely. There *was* no essential disagreement among Americans on the big issues of peace and preparedness, and the disagreements about civil rights and religion are so deep-seated and bitter that debate is dangerous and makes everybody uncomfortable. Unlike these larger issues, medical care of the aged is a near-perfect vehicle for political dialectic, touching both the heart and the pocketbook, but lightly, and providing the sound of disagreement without the fury — as different from civil rights and religion as a firecracker is from a bomb. Thus Democrat can accuse Republican of not caring *what* happens to Grandma, and everybody knows this isn't really true; Republican in turn can charge that Democrat is hiding under Grandma's shawl his evil intent to sell the nation down the river into socialism, and everyone knows *this* isn't true either. An official of the American Medical Association can declare portentously that the Forand Bill is the greatest crisis organized medicine has ever faced; biting back, a labor union spokesman can make the idiotic allegation that President Eisenhower doesn't understand the problem because he has always had free medical care in military hospitals. Gunfire and bloodshed abound; as in a TV western, however, the viewers understand that nobody is really getting killed.

While these exchanges are taking place to the delight of headline writers and partisans on both sides, interested government executives and legislators have been working hard to resolve their differences, which are the ones that really count, and develop compromise measures that have some chance of providing a little aid for the needy aged, and a little money for the hospitals and doctors that take care of them, without threatening the foundations of the republic. Once this is accomplished, possibly some thought can be given to an aspect of the aging-population problem that has been lurking behind the gunsmoke and may easily be worse for the aged than unpaid hospital bills and deadlier for the economy than creeping social-

ism — the widespread practice of compulsory retirement at age 65 or earlier. Whether the bills are paid by families through savings and investments, or by business and industry through insured pension plans, or by younger workers through contributions or taxes or both, the retired population is a monkey on the back of the body politic, and, as statistics on aging plainly demonstrate, the monkey is growing all the time and will soon be a man-sized ape. In due course we shall probably figure out some acceptable way to pay hospital and doctor bills for the sick and needy segment of the aged population, but it is doubtful that we can afford indefinitely to house, feed, clothe, transport and entertain the ever-growing fraction of the aged population that contributes nothing to the productive economy.

Unquestionably, it is comforting for younger workers to know that automatic retirement will predictably clear the way for advancement through the ranks, and it is easier for executives to point to the retirement rule as they present a gold watch and a pat on the back to Good Old Joe than it would be to tell him his memory is failing along with his eyesight and he'd better step down before he ruins the business. But compulsory retirement weeds out the healthy and alert along with the ailing, the productive as well as the faltering. It is an extravagant anomaly that robs able-bodied, able-minded men of the right to do the work of their choice and denies the nation the services of an increasingly formidable fraction of its most priceless resource, the working force.

Those Sunset Retreats and Golden Year Clubs and Senior Citizen Seminars are subversive of the national interest. What Grandpa needs is neither supervised quoits nor handouts, but a useful job. Give him back his overalls, and let him pay his own hospital bills.

Lights On

A STATE hospital review and planning commission backed up by regional councils representing hospitals, medicine, Blue Cross, labor, industry and local health and welfare departments is envisioned in the report of a two-year study of Blue Cross plans in New York State. The study was conducted by the School of Public Health and Administrative Medicine of Columbia University under the direction of Dr. Ray E. Trussell, and the recommendations may readily be reflected in action taken by the state superintendent of insurance on a current request for approval of a 37 per cent increase in rates for Associated Hospital Service of New York, the nation's largest Blue Cross plan.

Already authorized by the legislature, the commission recommended in the Trussell report would not have the power to enforce regulation of hospital operations; through the proposed regional councils, it would seek instead to prevent needless duplication of facilities and services, cut down unnecessary admissions and over-use of beds and other facilities, and coordinate planning for hospital, nursing home and related services in the community. In these and other activities the councils would define responsibilities, set standards and review performance — presumably in full public view whenever the councils or the commission felt that hospital performance might be improved by turning on all the lights. While it thus proposes no state hospital bureaucracy or control of a kind to cause crying at night among physicians, hospital administrators and trustees, the Trussell report certainly does contemplate a step away from individual hospital autonomy, and inevitably there are some who will moan, if not scream, for the good old days when hospitals, like country clubs, were nobody's business but the boards' and the doctors'.

Possibly because of widespread participation in prepayment plans, the good old days have vanished. The public has become increasingly aware that hospitals are not like country clubs, or even like private businesses. They are public institutions, at least to the extent of being tax exempt, and it is commonly understood today that they owe some public accountability for their management of what are in part public resources. Happily, there is no real outcry anywhere for hospitals to be managed by public officials, like jails and fish hatcheries. Instead, the Trussell recommendations comprehend an orderly minimum of accountability, supervised by groups in which the professions are well represented. Whether or not the recommendations are effected now in New York State or elsewhere, they propose a sensible evolution from the country club concept of hospital responsibility. It seems likely that the report will be applauded by everybody except the moaners and screamers, who have drifted so far downwind of the main body of thought in our society as to be scarcely audible.

Backfire

PUBLIC relations maneuvers we can get along without, permanently if necessary, include all those releases proclaiming in shocked tones that the U. S. spends more for tobacco and alcohol and recreation than it does for health care. The idea here must be either to persuade us that health care is really a bargain at today's prices or to demonstrate that we are all fools.

Either way, the releases seem certain to fail of accomplishing their purpose. Nobody really cares much about health costs, and so nobody is getting the message, until he is confronted with a hospital bill, say, or a Blue Cross rate increase. Then the instinct for self-preservation takes over and any bill is likely to seem exorbitant. If the purpose is to make the reader feel stupid, along with all his countrymen, to be spending so much for liquor and cigarets and so little for hospitals and doctors, he will probably miss the point completely, or, if he does acknowledge a fault, he will not thereupon feel any great love for the one who has called him fool.

In any case, the average person who reads that the nation's total annual health bill is only $16 billion and we spend $32 billion, or whatever, for booze, smokes and frolics may react the way the bartender did when he served a Martini with a twist of lemon to a patron who had specified "no olive, no onion, no lemon." The patron complained, and the bartender snapped back, "If you hadn't of mentioned lemon I'd a never thought of it." The reader puts down his newspaper or magazine, pours himself a drink, lights a cigaret and remarks that the price of hospital and medical care has gone up outrageously and somebody ought to do something about it.

The Atomedic research center described here will focus the talents of medicine, science and industry on the task of bringing a high quality of medical care within the reach of everyone

Electronics Is Changing the Structure of Hospitals and Medical Care

Jane Barton

DR. HUGH C. MacGUIRE, pediatric surgeon and founder of Atomedic Research Center, Inc., of Montgomery, Ala., has a bear by the tail.

When he starts to swing it, he is likely to upset most, if not all, of the present concepts of (1) hospital design and construction, as regards both the outer structure and the fixed and movable equipment; (2) medical care and diagnosis; (3) communications among medical practitioners all over the world; (4) medical and nursing education, and (5) medical economics, including prepayment for health. In addition, he expects to open up a whole new world to designers and manufacturers of hospital and medical equipment.

Let it be said at the outset that Dr. MacGuire is not proposing that Massachusetts General Hospital or the Mayo Clinic, the Oschner Clinic, or any of the other great medical centers, should close their doors day after tomorrow. Nor does he intend that the manufacturers of hospital and medical equipment should go out of business. He needs them all in his own business and has, in fact, been diligently enlisting the support of leading physicians and manufacturers in carrying out his project. He has also sought, and received, the support of a group of civic minded and imaginative businessmen in Montgomery, who helped him form Atomedic Research Center, Inc.; of scientists and industrial engineers, and of officers of the armed forces. The Air University at Montgomery, for example, has made its facilities available for two symposiums on the prob-



Dr. MacGuire

A Canadian by birth, Dr. Hugh C. MacGuire received his degrees (B.S., M.D., C.M.) from McGill University. Now a citizen of the United States, he established his practice as a pediatric surgeon in Montgomery, Ala., and was honored for his work in 1951 by the city's Junior Chamber of Commerce. Experience in building two hospitals set him off on the search for better ways of meeting today's hospital and medical problems and led, in the course of that search, to the founding of the Atomedic Research Center. Atomedics, Dr. MacGuire explains, is a composite of Atomic Age-Medicine, the wedding of science and industry to medicine.

Beauchamp Nolin, who built the scale model of the pilot Atomedic hospital shown on the next page, is a self-educated machine engineer. He is also, in Dr. MacGuire's words, "an expert in physics, electronics, chemistry, plastics and industrial management in the refrigeration industry." He and his brother own an international refrigeration research engineering company and an electronics firm.

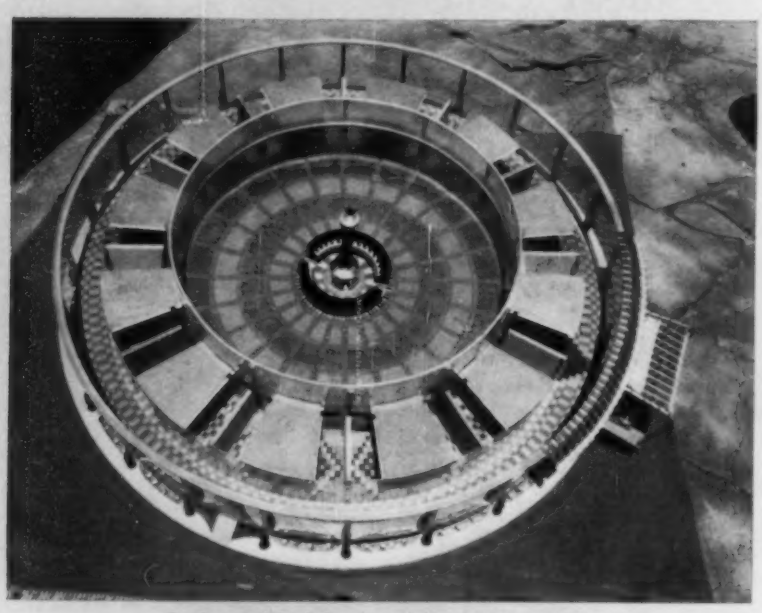
lems and potentialities of the Atomedic project and has offered all possible encouragement.

The immediate objective of Atomedics (derived from Atomic Age Medicine) is to set up a pilot hospital and research center in Montgomery at which every aspect of medical and hospital care can be studied on a continuing basis by all of the disciplines involved. In Dr. MacGuire's view, this includes every field that impinges on medical care, from architecture to nuclear physics.

The problems of steadily mounting hospital and medical costs and steadily diminishing supplies of professional people to care for patients, Dr. MacGuire contends, can only be solved by a concerted attack by leaders in all of the fields involved working together and pooling their knowledge and skills. Not until science, medicine and industry form such a working partnership will a constructive answer be found to what he terms the "present crisis in medicine." And it had better be found soon, he points out, or the answer will come from the government — a prospect that incites him to explosive fury.

The pilot hospital will look like no hospital on earth, for the excellent reason that it will incorporate materials and apparatus that are well known in science and industry but, thus far, have not been adapted to use in hospitals, except in scattered instances. (See description below.)

Revolutionary as the hospital building will be, however, it is simply the means to an even more revolutionary



Scale model of the Atomedics pilot hospital.

PILOT HOSPITAL

AS IT is presently envisioned, the hospital would be a circular structure, 100 feet in diameter, containing accommodations for 24 patients. The 100 foot size was selected because it will fit into the ordinary residential building lot — and the whole idea is to make these neighborhood hospitals, each serving a population of from 2500 to 5000.

Tough, lightweight plastic, mounted on hollow pontoons and covered with a double dome through which colored gases can be flowed to control heating and cooling, would form the outer shell. The pontoons can serve as storage space for equipment and supplies, and it is envisaged that the floors can be made in segments that can be raised automatically when the attendants want to get at the materials stored beneath them.

The scale model now being constructed for Dr. MacGuire by Beauchamp Nolin, a refrigerating engineer by trade and an electronics wizard by nature, is built in a series of concentric rings (see cut). On the periphery is the corridor for visitors, who will thus be kept out of the way of hospital traffic. Next come the patients' rooms, then, proceeding toward the center, the central work area, and, finally, the heart of the whole hospital.

At the core of this section is a chimney built over a small radioactive unit that will provide cold sterilization for instruments and supplies carried on a conveyor belt. Here, also, is the television switchboard and intercommunication system through which the nurse can keep track of all patients, minute by minute, and the magnetic tape recorders which will continuously record the information on patients' body functions such as temperature, blood pressure, pulse, and respiration transmitted to it by physiological transducers worn by the patients. This information can be stored on the tape and played back whenever the nurse or doctor wants to check up on a patient's progress.

Eventually, it is explained, the physiological data gathered by the transducers will be fed not only into the tape recorders in the hospital but into giant computers based in regional centers all over the world by long-distance telephone lines. Not surprisingly, this phase of the project has excited the interest and enthusiasm of telephone company officials, who look forward to the day when Atomedics will be their best customer.

Construction of the patient rooms may take one of several forms. In a brochure describing the Atomedics plan, Dr. MacGuire pointed out that at least two different types of interior arrangements are now possible. One uses light but rigid prefabricated partitions that are both self-supporting and sound resistant. They can be joined by new adhesives, and assembled in 30 or 45 minutes. A pre-

end, which is the true objective of Atomedics. That is to set up a time study on people of all ages, beginning in infancy and continuing throughout life, with the purpose of determining what health is and thus how to prevent disease. It is Dr. MacGuire's thesis that somewhere between Hippocrates and open-heart surgery the concept of health got lost, and all the attention of the medical profession has been focused on disease. The result has been the accumulation of a great body of knowledge about disease and virtually no knowledge of health.

Doctors don't really know what a "normal" being is, says Dr. MacGuire, because they only see people who have something wrong with them. Nor do doctors have any objective standards on which to base their diagnoses and treatment; they have only the subjective information given by the patients as to their feelings and symptoms, which may or may not be accurate. For example, Dr. MacGuire's patients (infants and small children) usually can't tell him anything at all; he has to figure the problem out for himself. Equally subjective, he asserts, are the doctor's own reactions, which is why no physician will accept another's findings on a physical examination of a patient. He must make the examination and laboriously write down his own findings, labor he could easily be spared if valid measurements were available with which the patient's symptoms could be objectively compared.

(*Text Continued on Page* 85)

WILL REVOLVE AROUND THE NURSES' STATION

fabricated plastic room, such as the one on exhibit in Disneyland, which contains a prefabricated bathroom, or reinforced plastic with the lighting fixtures and cabinet incorporated in the walls, also offers great promise.

It is Dr. MacGuire's hope that mass production economies will allow the production of complete hospital rooms with beds, tables and fixtures molded onto the walls. "If such a room can incorporate the heating and cooling panels which at least two companies are working on, and a sewerless toilet," he states, "it may be possible to offer a complete unit that can be plugged into a utility receptacle much as an extension cord is now plugged into an electrical outlet."

The flooring material will probably be metal honeycomb sandwich panel covered with an appropriate fabric to offer both sound control and softness under foot. "Our experience here with carpet has been quite satisfactory and maybe a nylon fabric, or one of the newer plastics, will be used. Only after developing and testing of various flooring materials in the prototype will some sort of final and economic decision be made," it is explained.

Flexible coupling, such as is now being used to attach home gas ranges so that they can be moved out from the wall for cleaning, might also be employed to attach the patient's bed to the plumbing and electrical facilities in the wall to afford greater mobility. Thus, if a patient needed surgery, the bed could be moved into the central work corridor and enveloped in a plastic tent that would create a sterile field to protect him against infection. "Why do we have to have a hospital operating room complex when the whole job can be done in a plastic sterile field?" Dr. MacGuire wants to know.

It was the complexity (one of his favorite words) of hospitals and hospital equipment, with their attendant expense, that afflicted Dr. MacGuire when he was preparing to build his own hospital and set him to searching for simpler, less costly ways of giving a higher standard of patient care than is now available.

In explaining the scale model to a reporter, Dr. MacGuire and Mr. Nolin pointed out that no provision had been made for either a kitchen or a laundry. As far as food service is concerned, they assert, it is perfectly feasible to stock a freezing unit built into the partition above the patient's bed with prepackaged frozen foods (tailored to the diet requirements of each individual). At meal hours, the frozen food can be dropped into an electronic cooker immediately below to bring it to edible temperature. Mr. Nolin, to whom the laws of thermodynamics are as beautifully simple as the alphabet, sees nothing remarkable in linking refrigeration and radiant heat. "It's just a matter of thermocoupling," he says. And he and Dr. MacGuire agree that such a method of food service — with all the buying, production and preparation done outside the hospital — will be less complex than existing food service setups.

The need for a laundry will be obviated by the use of plastics, paper and cotton substitutes for bed linens, cubicle curtains, uniforms, gowns and drapes. Disposable linens and operating room packs have been on the market and under test by hospitals for some time now. Such articles, Dr. MacGuire believes, can be mass produced at a cost far lower than that of conventional linen supplies.

The pilot hospital and all its components are designed for mass production. The day will come when there will be 100,000 to 150,000 in all parts of the country, Dr. MacGuire prophesies, and that will be a mass market worth going after. Although the initial investment in research and construction of the pilot hospital will be tremendous (an investment the officials of Atomedics hope will be underwritten by foundations and interested industries), once the patterns have been standardized, it is anticipated that costs will drop to the point at which the hospitals can be produced at a cost for the entire package of from $5000 to $10,000 per bed. And any neighborhood can afford to support a 24 bed hospital at this price, Dr. MacGuire believes. ■

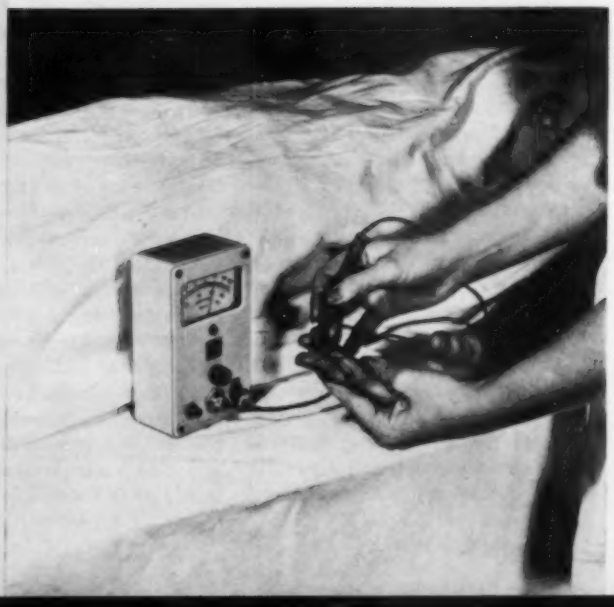
THESE ELECTRONIC DEVICES ARE ALREADY AT WORK IN U.S. SPACE PROGRAM



Transducer (above) mounted in mask measures the flow of respiration. It senses respiration rate and depth of air through oral-nasal passages during breathing.



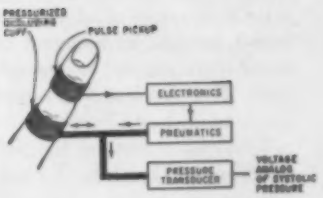
Blood pressure gauge measures blood pressure in heart chambers as well as in vascular system with extreme sensitivity.



Electronic skin thermometer can be used for rapid, direct recording of skin, rectal and oral temperatures. Device would be useful in measuring patient's temperature during surgery.

Photographs on this page and diagram opposite, courtesy Gulton Industries, Inc., Metuchen, N.J.

FLEXIBLE IS WORD FOR NEW HOSPITAL



Reading of maximum systolic pressure is given by pressurized occluding cuff worn around the finger and connected to pneumatic system. Pulse pick-up at end of finger detects pulsations caused by volume changes in blood at tip of finger.

(*Continued From Page* 83)

The great obstacle to making medicine truly scientific, he is convinced, is the lack of known constants, *i.e.* standard measurements and tests that can be universally applied, and the inability to catalog and correlate all the information that has been accumulated by medical practitioners and researchers all over the world. Much information exists but it is useless if people who need it can't get at it, he points out. What the doctor in Montgomery, Ala., learns from his studies should be immediately available to the doctor in Peru or Pakistan, and there should be a universal measuring system so the doctor in Peru can compare his findings with those of the doctor in Montgomery.

Building Blocks Progress

Another obstacle, almost as great in Dr. MacGuire's view, is the unwieldiness, inflexibility and enormous cost of hospitals, which are the physician's laboratory. Hospitals cannot keep up with the racing strides of technology because they just won't budge. Once a hospital has been built, it sits there stolidly for the next 50 or 100 years – by its very nature blocking the path of progress. Remodeling and expansion to keep up with new technics and increase patient loads are so expensive that they are undertaken only as a desperation measure, and usually result in increasing the cost to the patients.

When the demand for care outruns the ability of the hospital staff to render it, instead of installing mechanical and electronic devices that could take some of the burden off the staff, says Dr. MacGuire, the hospital's solution is to hire more people – at greater expense. This solution seems to be the only one because, again, the rigidity of hospital construction prevents the use of machines instead of people.

The solution proposed by the founders of the Atomedic research hospital, and their colleagues in science and industry, is exactly the opposite. They intend to construct a hospital that is flexible and mobile enough to be adapted to the changing needs of the patient load and that can even be picked up and moved should the need arise.*

It would do away with such areas as the operating room, the kitchen and the laundry, with all their massive equipment, and would substitute electronic devices for the footwork and paperwork now required of the nursing staff. It would, furthermore, bring the hospital back to the patient's neighborhood and the doctors and nurses back to the patients.

Mass production and standardization are the essence of the Atomedics project. Manufacturers of the transducers and other electronic instruments to be used in diagnosis; of the computers, which are expected to play such an important role in both research and in performing routine hospital jobs, and of all the other ma-

*Michael Hack, an Atlanta architect, is working with Dr. MacGuire on the pilot hospital. Consulting architect on the project is Dean Sam Hurst, head of the school of architecture and art, Auburn University, Auburn, Ala.



Photograph courtesy Blonder-Tongue Laboratories, Inc., Newark, N.J.

Artist's concept of a tiny, flexible television camera now being tested. It could be mounted on the surgeon's head and worn like a Mandarin's pigtail, broadcasting the operation to a distant audience. The camera could also be inserted in the patient's body.

What Health Leaders Think of Atomedics

"The innovations and construction envisioned here and the utilization of electronic and automated equipment will make invaluable contributions to the physician's skills and efficiency. To see this hospital in operation would certainly be one of the high spots of my professional career."

Louis Orr, M.D.
President
American Medical Association

"I think you are doing one of the most interesting things that is being done in the country, with possibilities of great achievement, and I will have a continued interest in it."

Russel V. Lee, M.D.
President
Palo Alto Medical Clinic
Palo Alto, Calif.

"Your idea of a health research hospital is interesting and has some exciting possibilities. I think your medical research program holds tremendous promise for the future."

A. A. Lepinot
Administrator
Roswell Park Memorial Institute
Buffalo, N.Y.

"I wish to congratulate you on your ingenuity and foresight in anticipating hospitalization trends."

Victor Johnson, M.D.
Director
Mayo Foundation
Rochester, Minn.

"You are clearly on the trail of exciting contributions to medicine and medical research. If, at a minimum, you could come up with a hospital so designed as to be capable of mass production in all of its parts, you would have made a contribution of significance for the whole country."

Robert T. Monroe, M.D.
Board of Trustees
Age Center of New England
Boston

ATOMEDIC CENTER

terials, supplies and equipment that will be incorporated in the pilot hospital cannot possibly afford to produce them for a few scattered institutions – and it is a rare hospital nowadays that could afford to buy them. But what they can't afford to produce for five or 50 hospitals, they *can* afford for 100,000 or 150,000 hospitals.

In a recent letter, Dr. MacGuire explained: "The hospital must be economical so that everyone can afford to be studied and cared for. It can be economical if it is automated and mass produced. It can be mass produced if a standardized design is created. Standardization of design includes standardization of instruments and devices used in creating a meaningful human equation."

Asked whether objections might not be raised that standardization would destroy competition among manufacturers, Dr. MacGuire replied that the function of the research center at Montgomery would be to work out the basic patterns of all elements of the hospital, write the specifications, and assemble the complete hospital "package." Production of the various components – building materials, beds, sterilizers, freezing and cooking units, electronic instruments, and so forth – would be the job of the manufacturers. Thus, the research group could carry on a continuing study and evaluation of the elements of the hospital and puts its seal of approval on them – as the Underwriters Laboratories now approves electrical appliances. Control of the designs by the Atomedics group is essential, it is explained, so that there will be no deviation from the standards and also to ensure universal acceptance. So far from inhibiting manufacturers, this system is expected to open vast new markets to them. And the manufacturers will be invited to participate in the research program, help to draw up plans, review the developments in

WILL TEST INSTRUMENTS, MATERIALS AND TECHNICS

their special fields, and establish policies regarding proprietary rights.

The Atomedic research center, as its founders see it, will be a vast testing laboratory not only for new developments in design, instruments and materials, but also for new technics in hospital administration and operation, in work simplification – especially nurses' work – and in medical and nursing education.

Nurse Will Do More

Nurses and doctors, Dr. MacGuire contends, are rapidly approaching the status of vanishing species. In support of this view he cites the continuing, desperate and largely futile efforts of various agencies to entice recruits into nursing and the alarmed statements by medical educators regarding the decrease in applicants for medical schools. He considers it inevitable that this trend will continue, that "shortages" of nurses and doctors are here to stay, and that the only solution is to conserve the time and energy of such professional groups for direct patient care. With improved communication systems and automated patient evaluation systems, freed of the routines that occupy so much of her time, Dr. MacGuire believes, one nurse will be able to handle a patient load that today requires the services of many. In the pilot hospital, it is contemplated that one professional nurse on each shift, assisted by two or three aides and students, can easily care for all 24 patients. Dr. MacGuire strenuously resists the suggestion that the nurse in an automated hospital will herself become no more than an automaton who never sees a patient except on a television screen. Automation will give her time to spend with patients that she doesn't have now; time to be a real nurse instead of an overeducated errand girl.

He believes, too, that establishment of small truly neighborhood hospitals, as opposed to large medical centers, will reverse the trend toward specialization in medicine; that putting all classified medical knowledge into computers where it will be instantly available to any doctor will bring the generalist back into his own. The patient will no longer be "subdivided" among many specialists; he will be treated as a whole being by one doctor whom he knows and trusts. Dr. MacGuire foresees the day when there will be medical teams and surgical teams – and that's all, as far as specialization is concerned.

Change in Medical Education

It is Dr. MacGuire's hope that the Atomedic hospital will effect a drastic change in many of the present-day concepts of medical and nursing education. He would like to see the doctor of the future, after he has acquired a certain amount of basic education in medical school, get his real training on the job in the small hospitals under the tutelage of the older physicians. This would, in effect, be a return to the apprentice system of medical education, with the difference that the young doctor's progress and ultimate fitness to practice medicine could be continuously measured through automatic testing devices. "As things are now," says Dr. MacGuire, "the time spent in getting an education is overshadowing quality of the individual in determining whether a student is ready to practice medicine."

He pointed out that with all the opportunities in other fields of science open to them, young men these days simply do not have the incentive to go into the long arduous training required of the medical student today – and so fewer and fewer of them are applying. Education by preceptorship might help to reverse this trend. If the medical student could work while he is getting his training and be paid for assisting the older physicians, instead of investing thousands of dollars in an education before he can hope to make a living, as is now the case, a medical career might be a more inviting prospect, Dr. MacGuire believes.

Nurses, too, could be trained right in the hospital under the supervision of the professional nurse, instead of wading through a five-year university degree course, in Dr. MacGuire's opinion, and be qualified under a new system of nurses training.

Inasmuch as the Atomedics project was generated by a desire to bring the best possible health care within the economic grasp of every person in the country, the question arose as to how the project could be financed and what means could be devised for ensuring that everybody would be able to afford the kind of continuing care Atomedics is working toward.

Where Money Will Come From

Funds for the pilot hospital and research program, obviously, will have to come from grants from various foundations and from the industries that will benefit from the program when it becomes a reality. After that, Dr. MacGuire's answer is simply "prepayment – voluntary prepayment." He proposes that all members of the community in which a hospital is located should pay a fixed monthly sum which would entitle them to all the care they need, when, as and if they need it. It would be up to the doctors on each hospital staff (and he estimates that there will be about three to six physicians serving a population group of 2500 to 5000) to sell their patients on the benefits of such a plan. The vision of doctors selling prepaid health service to patients may come as a distinct shock to the more conservative members of

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Patient Doesn't Swallow Nomenclature, U. S. Senator Tells Drug Practice Hearing

WASHINGTON, D.C.—The arguments about duplication, substitution and prescription practice that have enlivened hospital and pharmacy meetings in recent years were transferred to the halls of Congress last month and continued in full voice, with members of the U. S. Senate subcommittee on antitrust and monopoly looking on and, occasionally, taking part. For several days of hearings and several hundred pages of transcript the committee, its staff and numerous witnesses wrestled with the perplexing economic and professional problems that have emerged in the modern, drug-a-day world; especially, they were concerned with the putative economies, and the possible hazards, of ordering prescription drugs by generic instead of trade names, as it is done in many hospital formularies. The practice was advocated by some professional witnesses and condemned by others.

Members of the committee kept apologizing for their inability to pronounce pharmaceutical names and grasp pharmaceutical problems, but it was a minority committee member, Sen. Roman Hruska (R.-Neb.), who cut through all the confusing talk to a hard core of truth about which there could be no argument: "A patient doesn't swallow a nomenclature," he said. "He swallows certain substances. The question is whether he would get the same substance . . . if the prescription were written in generic terms."

As it finally emerged after four days of hearings, the answer to Senator Hruska's question was plain enough: Under most circumstances the patient can't depend on getting the same substance. Some purchasers like the armed forces and a large university hospital whose methods were described during the hearings may have resources to conduct tests of the purity and potency of "generic equivalent" drugs, it was explained. But many hospitals and pharmacists have no such resources to safeguard patients, it was pointed out, and even precisely equivalent chemical agents may have varying bases, vehicles, coatings or other characteristics that might affect the efficacy of the drug for a particular patient. **"A generic name is used for a specific chemical substance and has no connection with the pharmaceutical dosage form or brand name product," Charles O. Wilson, dean of the school of pharmacy at Oregon State College, told the committee. "There is no such thing as a generic equivalent," he added.**

Another professional witness, Dr. August H. Groeschel, associate director of the New York Hospital, described that hospital's formulary program and defended the use of "official or nonproprietary terminology." The hospital's pharmacist had estimated the formulary system resulted in savings to the hospital of $250,000 a year in drug costs, Dr. Groeschel reported. However, the first effort is to get reliable drugs, he said.

Asked how the hospital would determine a reliable product, Dr. Groeschel replied: "If there is any question in the mind of the pharmacist and formulary committee, they might very well ask certain departments' research laboratories in our medical college to do special testing on the drugs . . . We do have more machinery in the university teaching hospital for doing this kind of thing than the average hospital has."

Since the hospital obtains the consent of staff physicians to the operation of the formulary system, Dr. Groeschel said, "We are, in fact, dispensing to the patient precisely what the doctor ordered. We are not substituting."

Another witness from the New York Hospital, Dr. Walter Modell, chairman of the hospital's formulary committee and associate professor of pharmacology at Cornell University Medical College, testified that use of nonproprietary names was necessary for teaching purposes. "If a subject is to be taught, the materials with which it is concerned must be identified," he said. "Only nonproprietary names always tend to identify the nature of drugs and, therefore, as a general rule, only by using them can one communicate meaningfully about drugs and instruct students on the nature of drugs and their effects on the human body . . . Trade-mark names often introduce confusion in an already difficult and complex subject by providing more than one name for the very same drug; sometimes there are as many as 25 proprietary names for the same thing."

Acknowledging that many physicians relied on the reputation of the manufacturer as a guarantee of quality, Dr. Modell advocated the practice of prescribing by the nonproprietary name and specifying the manufacturer.

The method recommended by Dr. Modell amounts to the same thing as prescribing by trade name, Dean Thomas B. Rowe of the University of Michigan's college of pharmacy told the committee. "Physicians when prescribing trade names are also specifying a manufacturer, because physicians have learned to rely on the integrity of the ethical pharmaceutical manufacturer," he said. There is nothing that now prevents physicians from prescribing by generic names if they want to, Dr. Rowe added. But, he warned, the result would be "utter chaos" if all prescriptions were written by generic names. "Physicians themselves are totally unfamiliar with these names . . . The average pharmacist would be lucky if he could figure out the physician's intent on half the prescriptions he received."

Several witnesses pointed out that resources of the Food and Drug Administration are inadequate to permit proper testing and inspection of drug products. "Control testing costs money," said Lloyd C. Miller, director of revision of the U. S. Pharmacopeia. "The money has to come from someplace, and it usually is reflected in a higher selling price for the drug."

Mr. Miller also recommended prescribing by the nonproprietary name and specifying the manufacturer. He agreed with a staff member that it was a "gamble" to prescribe the nonproprietary name and let the phar-

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Sawtooth pattern shown on east facade of Eveleth Fitzgerald Community Hospital provides a shield of masonry against the wind and snow, but gives patients the advantage of prevailing winds and sun through glass panels.

The Modern Hospital of the Month

Sawtooth Plan Shields Patients From Biting Winter Winds

WHEN the north winds blow in the Iron Range of Minnesota, they bring heavy snow and cold that often drops temperatures to 40 or 50 degrees below zero. So the architects of Eveleth Fitzgerald Community Hospital, Eveleth, Minn., made plans to protect patients from the cold north winds and still give them the benefit of the south sun.

The plans took the form of a sawtooth pattern for the exterior walls in the nursing wing. This pattern, Architects S. C. Smiley and Associates of Minneapolis explain, provides a shield of solid masonry against wind and snow.

The southerly sides of the rooms in this wing were, however, constructed of porcelain panels and glass to take advantage of the prevailing winds and south sun in summer.

An additional benefit of the sawtooth arrangement, the architects say, is that the bay formed by the V of the sawtooth in each nursing room gives

All nursing rooms are semiprivate and identical with one shown below, except for isolation rooms. This simplifies service and housekeeping problems, and placement of beds gives each patient a complete view of exterior to the south.



OUTLINE OF CONSTRUCTION COSTS

Total cost		$863,428.00
No. of beds (planned for 20 additional)	52	
Cost per bed		16,604.00
Total square feet	33,314	
Square feet per bed	640	
Cost per square foot		22.97
Total cubic feet	354,129	
Cubic feet per bed	6,810	
Cost per cubic foot		2.16

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.

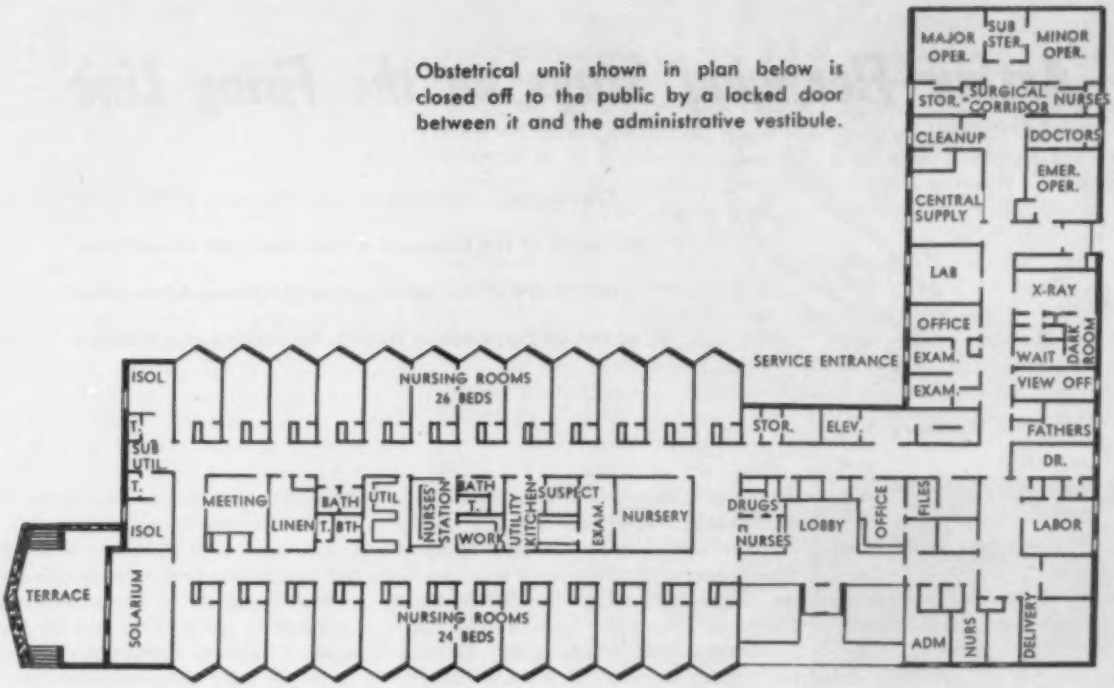
SIMILARITY OF ROOMS

more area to the interior and eliminates the monotony of the usual rectangular box. Placement of beds against the northerly walls of each nursing room gives each patient a complete view of the exterior to the south.

All nursing rooms are semiprivate and all are identical, except for isolation rooms. This similarity of rooms and furniture arrangement simplifies service problems and housekeeping problems, hospital officials point out. The arrangement also makes it easy to move beds, food carts, stretchers and other equipment in and out of the room.

The obstetrical corridor is closed

Obstetrical unit shown in plan below is closed off to the public by a locked door between it and the administrative vestibule.



AND FURNITURE ARRANGEMENT SIMPLIFIES SERVICE

off to the public by a locked door between the administrative vestibule and the OB unit. However, the lock is set so that persons going from the corridor back to the administrative area have free access without using a key. The nursery was purposely located away from the obstetrical area, the architects state. It is so placed that the nurses' station is in control of it at all times, plus reducing the number of employes needed during off-hours.

Centering the nurses' station in the island service core of the nursing wing makes all rooms immediately visible and permits room calls to be answered without delay. The location of the station and the nursery has been favorably received by staff members and the administrator, and approved by the state health department, it is stated.

An unusual feature of the design that paid an unexpected dividend is the stained glass window panels flanking the main entry and public lobby. The stained glass was used to reduce glare in the lobby, and the effect of the subdued light, it has been found, has been to induce visitors to speak softly once they are inside the building.

The lower level of the hospital contains the boiler room, centrally located to make the mechanical runs comparatively short. Tunnels provide access to the mechanical lines under the nursing wing. Roof vents, exhausts, air intakes, and electrical services have been housed on the roof in such a way as to present a unified, orderly exterior appearance.

The hospital was planned for 50 beds and is expansible to 70 when the demand for service requires additional space. Administrative areas, operating rooms, kitchen, cafeteria, laundry, storage and other facilities are adequate to serve the additional beds. Funds for the project were contributed by members of the community of 6000 persons served by the hospital. ■

Arthur Flemming Stays on the Firing Line

Cranberries, carcinogens and the care of the aged are three of the issues that have brought controversy and glare of the limelight to the present Secretary of the Department of Health, Education and Welfare

George Connery

SECRETARY of Health, Education and Welfare Arthur Flemming was having a conference in his office when the phone rang. It was "from the White House," meaning not the President but someone speaking for the President.

Flemming listened for a while, protested moderately at whatever was being proposed, then flushed and blurted out: "I'll be damned if I will." That was about the end of the conversation.

From many other Cabinet members, and even lesser officials with backbone, this would not be amazing. But for the Cabinet's "All American Boy" to rear up this way was unprecedented.

For the Secretary has the reputation of never getting really angry, never swearing, never letting any situation get out of control. Despite the exacting work schedule he imposes on himself, Secretary Flemming is almost always polite, usually affable – and never physically exhausted.

One of the Secretary's intimates said he couldn't object to the "All American Boy" description, except that Flemming's quite a bit more than a boy. He is a superb administrator, a tireless worker, an adroit operator in public relations, personnel problems, and politics.

Why "The All American Boy"?

Merely because he is completely unspectacular as a person, but is spectacularly efficient in his work. He has almost no part of the surface bustle that is supposed to be essential to the machinery of government – cocktail parties, formal dinners, backstage maneuvering. Yet he is a remarkable diplomat, perhaps because he knows just about everyone of any consequence in Washington. Flemming firmly separates his personal life from his official life; some of his top executives have never been in his home. He keeps long hours, and is on the job six days a week. A daily walk part way to his office constitutes his "exercise." He practices his religion – he's a Methodist – the way he does everything else – with devotion and energy. He is a lay preacher and is a former vice president of the National Council of Churches of Christ in America. Flemming has amply demonstrated that he can handle an amazingly complex department (better than it has ever been handled before) without showmanship – and without smoking or drinking.

One of the problems of the Eisenhower Administration is to find capable Republicans to fill top jobs in the welfare fields. In these areas the President himself is moderately liberal – or humanitarian – but the hard shell of Republican leadership in Congress is not. Flemming has fitted into this role as few men could.

The liberal Democrats in Congress know that basically Flemming sympathizes with them when they are talking about satisfying human needs and not plotting to gather up votes.

The conservative Republicans may not like him, but they know that he understands his business, that he is a bear for the factual argument, that he is tenacious beyond all limits – yet that he's a "team man."

His team spirit right now is being put to a fearful test. After spending a year studying the problems involved in financing the medical care for the aged, Flemming himself decided a social security hospitalization program was the only sound answer.

In the White House or the Budget Bureau or both he was rebuffed. That was hard to take, but not too hard for a person who has grown to maturity on negotiation and compromise. A few crisp but not bitter remarks were his only reaction. Then, outwardly optimistic, he went back to working up a program that would satisfy everyone. The task was discouraging, but eventually his compromise was presented to Congress, in plenty of time for enactment – if that was what the Democrats wanted. They obviously didn't. Yet, if the Democrats take the social security approach to health care for the aged, Flemming can be depended on to fight them all the way. Not because he doesn't agree with them – he does – but because he's part of the other team.

Where is he going from here? He won't say, obviously, but it would be unrealistic to expect him to go back to the presidency of Ohio Wesleyan University. He is an unannounced candidate for vice president on the Republican ticket, but it is likely he has ruled himself out of that by his outspoken stands on food additives that may be carcinogenic (cranberries, poultry), his liberal policy on health care for the aged, and the generally

Mr. Connery is Washington correspondent, The Modern Hospital.

chilly atmosphere that he generates among his party's hard-core conservatives.

It is a matter of record that he has made many, many trips to Ohio for speaking engagements. He would seem to be a natural as a candidate for senator or governor when the right time comes.

There is no magic in the way the Secretary operates.

His top executives say that he knows far more about the detailed workings of their departments than any other Secretary of H.E.W. or administrator of H.E.W.'s predecessor, the Federal Security Agency. He "digs deeper" than the others, perhaps a holdover instinct from his years as a Washington journalist.

Also, there is hardly a document of importance that goes out from H.E.W. that he does not personally edit. This applies particularly to his speeches and his testimony.

His own speeches – even those prepared in 10 minutes – have a polished tone. The oratory itself may be a bit too stylized – a college orator, he rounds out many sentences with an unimportant phrase that serves no purpose except to give him an excuse for emphasis. He will finish off a sentence, for instance, with "at this time," raising his voice.

Through his many years of weary traveling through Washington's bureaucracy, Flemming has acquired amazing skill in bringing a reasonable compromise out of argument and chaos. "I think his greatest asset," one H.E.W. official said, "is his willingness to listen you out, to really absorb your arguments."

Naturally, he is skillful at public relations, "Better than any of the rest of us, when we stop to admit it," says Jack Fletcher, information chief at the National Institutes of Health.

While Flemming will wait long and patiently for a compromise, if he can't get that he will take a stand and hold firm. When Food and Drug Administration determined that the chemical being used on cranberries was carcinogenic in the amount left on the crop, it so informed the Secretary. He called in cancer experts from the N.I.H. "They scared the daylights out of him," one observer said.

From that point on Flemming has

(*Continued on Next Page*)

Mr. Flemming Makes a Career of Public Service

Arthur Flemming was born at Kingston, N.Y., the son of an attorney. His first college degree was from Ohio Wesleyan in 1927. Then followed an M.A. from American University in Washington, D.C., in 1928 and a law degree from George Washington, also in the capital, in 1933.

His marriage, to the former Bernice Virginia Mole, also is a product of the campus: He met her when she was registrar and political science instructor at American University when he was director of the school of public affairs there in 1934. He served in this post for five years, and also did editorial work for the publication that now is *U.S. News & World Report*.

President Roosevelt appointed Flemming as Republican member of the U.S. Civil Service Commission in 1939, when Flemming was only 34 years of age.

Now Flemming was launched on a government career that, despite the prosaic titles of the jobs, is remarkable for the number and variety of his positions. And in between he has slipped back to Ohio Wesleyan twice for brief periods to serve as its president.

He served out his full term on the commission, until 1948. This meant he was deeply involved in World War II manpower problems, particularly recruitment for civilian government service. While membership on the commission is regarded by many as a full-time responsibility, Flemming over these years took on a complex of other assignments. Here are a few of them: chief of the labor supply section, Office of Production Management; chairman of the management-labor policy committee; member War Manpower Commission; navy manpower consultant; and a member of the International Civil Service Advisory Board.

When his Civil Service Commission term expired, Flemming had his first tour of duty as Ohio Wesleyan's president. But in 1951 he was back in Washington, this time as assistant director of the Office of Defense Mobilization.

Many of these titles, obviously, are not too descriptive, and all of them have a dull, bureaucratic flavor. Yet most are posts of tremendous responsibility.

Washington is well stocked with government employes of varying competence who would like to be elevated to such top-level jobs as Flemming has held. But it is an established fact that really good executives are scarce.

Two years after joining the Office of War Mobilization, Flemming was made its director and a member of the National Security



Arthur Flemming

Council. By invitation of the President he began to sit in at Cabinet meetings. Also, at about this time he was appointed to the President's Advisory Committee on Government Organization, which he now heads.

After four years with O.D.M., Flemming again moved out of the Washington scene, but within sound of a call. He returned to Ohio Wesleyan. This time the school was to lose its president in even shorter time—one year. In the summer of 1958 Flemming became secretary of the Department of Health, Education, and Welfare.

stoutly resisted White House, congressional and industrial pressure as far as carcinogens in food are concerned.

If Congress finally passes a medical care for the aged bill — Forand's or any other — Flemming's role will have been a prominent one, but politics being what it is, he won't get the credit.

The Secretary has worked tirelessly since coming into office to develop some sort of a program acceptable to the powers he must satisfy — the White House and Republican congressional leaders. The President, interested personally in helping the old people, is frightened at anything that may be called socialistic. Even so, he came right up to the edge of the Forand principle this year before backing away.

In Congress, most of the really heavyweight Republicans are even more determined than the President to have nothing to do with a socialistic program.

A year ago Flemming lined up with these views. Testifying before the House ways and means committee on the Forand bill, he was the most articulate and convincing of all opposition witnesses. His testimony reinforced the naturally conservative committee and it did nothing with the bill.

When he was being questioned last summer, Flemming promised that he and his experts would continue working on the problem until they found a solution. He has kept his word. More than that, when he and his staff finally had to admit the only true solution was a Forand-type bill, he reversed his position of last year and attempted to win over the White House and Republican members of Congress.

From this point on Flemming was gradually beaten back, but he made no public complaint.

The Secretary reached his high water mark at a news conference in February, after President Eisenhower the day before had admitted the Administration actually was considering something like the Forand bill. His words were revealing, coming from a Republican cabinet member who six months before did all he could to block the Forand bill:

"It is true as the President indicated that among the various proposals we are looking at is use of the social security payroll tax to help the aged handle payment for care in catastrophic illness — long and major illnesses. We are continuing to explore this possibility. . . . We have not found any way to do this — handle this problem — without the use of social security. . . . No evidence has developed to lead to a contrary conclusion — to conclude that the problem can be solved solely by working it out with the purely private insurance groups. . . . I have made no recommendation to the President.

"There is no question in my mind but that this is a serious situation. I find that wherever I go people are concerned with this — they're talking about it all the time, whether they are conservatives or liberals. This is of deep-seated concern to the American people. I certainly hope the Republican platform will come to grips with this problem."

For a few days it appeared the Administration, like Flemming, was about to make a 90 degree turn. Flemming and his staff informed the White House that scores of Republicans in Congress were insisting the Administration take positive and bold action to save them from defeat this fall.

Flemming's humiliating defeat occurred just the day before he was to testify before a Senate subcommittee. Presumably he had hoped to unveil his own version of the Forand bill.

He didn't get the chance to.

All 10 Republican members of the House ways and means committee jointly laid down the law to the President, to Flemming, and to Vice President Nixon, who was showing an interest in Flemming's ideas. They said that they would vote against any bill resembling Forand's even if it came from Flemming and the White House. They were strongly supported by Republican leadership in Congress and that was that.

Now Flemming had the embarrassing task of going up to the Senate subcommittee, most members of which were aware of the Republican family quarrel, and declaring:

"We do not believe that compulsory health insurance (the Forand principle) constitutes a sound approach. . . . We have not reached a conclusion as to the best manner in which to deal with such basic issues. . . ."

He promised to go back and try again. The Secretary hurriedly arranged a schedule of day and night conferences to go over the dusty reports.

However, before he could work up another plan eight liberal Republican senators introduced their own

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Mr. Eisenhower's Views on Health Insurance Legislation

Q. Mr. President, can you tell us anything of your Administration's plans to send Congress a health insurance bill at this session?

A. Well, I have got, I am preparing now a message for Congress giving my great concern about several bills, and the only reason that is holding it up is that we have not yet been able to coordinate, to bring together the various aspects you might say of this great problem and try to make a sensible unit out of the literally dozens of different proposals and alternatives that have been suggested.

Now, everybody agrees that in this field is a problem. Some of it, of course, is exemplified in very typical cases, but there are all sorts of areas in which this is attacked, local, state, Federal, voluntary methods and every other kind of thing. The only thing to which I am utterly opposed is compulsory insurance in this field, and to put the matter in the O.A.S.I. by adding on a half per cent of taxes, half for the workman and half for the company, does not seem to me to be suitable because I regard that as a compulsory affair. — *Transcript from President Eisenhower's news conference, April 27, 1960.*

American Nurses' Association Seeks Merger

Delegates move toward union with National League for Nursing, approve a more active role for A.N.A. in nursing education, and reaffirm their faith in collective bargaining as part of their economic security program

MIAMI BEACH. – The sun shone bright on more than 6000 nurses who attended the biennial meeting of the American Nurses' Association here last month.

Unfortunately, the ladies had little time for lounging. Ignoring the surf, most of them waded instead through a heavy schedule of educational and business meetings.

The A.N.A.'s hefty 1195 member house of delegates, which, like Gracie Fields' aspidistra, may be the biggest thing of its kind, produced the largest splashes at the meeting, although it did not go near the water. **In actions of particular interest to the hospital field, the delegates:**

– Included several planks in the A.N.A.'s 1960-62 platform that reflected the "association's concern and responsibilities in the area of nursing education," a move interpreted as another step toward fulfilling the avowed aim of the A.N.A. to establish one national group for nursing by merging with the National League for Nursing. The League heretofore has been responsible for most national nursing educational functions including – to the occasional dismay of the American Hospital Association – nursing school accreditation. Some observers familiar with the workings of the A.N.A. felt that, merger or not, the A.N.A. will ultimately seek control of nursing school accreditation, thus setting up a possible three-way tug of war over the program among A.N.A., N.L.N., and the A.H.A.

– Reaffirmed their faith in the A.N.A.'s economic security program and the collective bargaining approach by calling for "immediate and continuing action to secure compulsory social security coverage for all nurses in all types of employment."

– Almost but not quite dropped the Georgia State Nurses Association for failure to admit Negro nurses to membership, but instead postponed the decision by giving the state group two more years to comply.

– Reelected Mathilda Scheuer of Philadelphia president of A.N.A.

Since 1958, when the A.N.A. officially went on record as believing that "one national organization can best meet the needs of nurses," the A.N.A. (190,000 members) has worked with the National League for Nursing (22,500 members) in an attempt to merge the two organizations painlessly or redivide their duties. The N.L.N., however, has been notably unenthusiastic over the idea.

"It wouldn't be merging, it would be *submerging*," one N.L.N. sympathizer complained *sotto voce*, as Frances L. A. Powell, chairman of the Committee to Implement Resolution on One Organization, gave her report to the house. She indicated that the A.N.A. will move into the area of nursing education with or without the cooperation of N.L.N. The house accepted the report with little comment.

The National League for Nursing is expected to act on the A.N.A.'s standing invitation for joint study of the problem at its meeting next year. Meanwhile, to keep the ball rolling, the A.N.A. voted to establish a new committee, the Study Committee on the Functions of A.N.A., to determine what functions the A.N.A. must carry if "it is to discharge its responsibilities to the public and to the nursing profession."

The nurses' economic security program got full speed ahead from the house of delegates as it approved a resolution from the floor designed to strengthen economic security efforts for A.N.A. members.

The resolution, introduced by the Michigan State Nurses Association, called for a strong public information campaign for the A.N.A.'s economic security program, and followed the report by Anne Zimmerman, chairman of the A.N.A. Committee on Economic and General Welfare.

In her call for action on this issue, Mrs. Zimmerman urged the delegates to have "enough humility to acknowledge the economic poor health of the nursing profession and continue to speak out courageously through our professional organizations to improve it."

Supporting Mrs. Zimmerman's position, Matilda Young, a member of the A.N.A Committee on Economic and General Welfare, urged the house of delegates to fight for the elimination of "legislative discrimination against nurses."

It is, she said, "shocking that nearly 40 per cent of nongovernmental hospitals in the United States are not covered by the O.A.S.I. system." Getting in a plug for collective bargaining, Mrs. Young reminded her audience that the efforts of the A.N.A.

will be greatly facilitated "if each state nurses association would make it clear to their congressmen that the exemption of nonprofit hospitals from the Taft-Hartley Act has created a most unfavorable climate."

The proposed A.N.A. platform for 1960-62 also backstopped this position by retaining a plank committing the A.N.A. "to assist nurses to improve their working conditions through strengthening economic security programs, using group technics such as collective bargaining."

A few attempts at amendment of the plank from the floor, including a proposed deletion of the words "using group technics such as collective bargaining," were defeated after a flurry of discussion.

Also included in the approved platform was one new plank, which placed the A.N.A. squarely on record in favor of a more active role for the organization in nursing education. The new plank, which was greeted with some anguish by supporters of the National League for Nursing, called for the Association to "continue to elevate the standards of nursing education by formulating basic principles of the education essential for effective nursing practice."

Earlier, Mathilda Scheuer, A.N.A. president, chided the American Hospital Association for its stand on collective bargaining. The A.H.A. statement on this issue, she said, was not delivered until 15 months after it was requested by the A.N.A., and, "needless to say, we did not take any joy in the nature of the response."

The A.H.A.'s 15 month delay in answering the A.N.A.'s request for a statement on collective bargaining, and its subsequent disapproval of this technic, proved to be a favorite springboard for speakers who discussed this issue until A.H.A Nursing Consultant Eleanor Lambertsen, obviously nettled, rose to a point of information. Commenting on the 15 month delay, she pointed out that the American Hospital Association's procedure was similar to that used by the A.N.A., where policy matters go through committee to the house of delegates before they can become policy. The American Hospital Association, she said, considered the A.N.A. request as "part of the over-all issue of collective bargaining in hospitals" and issued a broad policy statement rejecting this approach; the statement, she emphasized, did not single out individual organizations. Miss Lambertsen then icily suggested that the A.N.A. "look carefully at communications that might further sever its relationship with other associations."

Later on, the A.N.A. voted to support the principle behind the Forand bill — health insurance as a part of social security benefits. In discussion among the delegates, a statement was read on behalf of a member of the House ways and means committee, which has considered this legislation for several years. In his statement, the congressman suggested that it was his impression some of the nurses did not fully understand the intricacies and ramifications of this legislation. He recommended further study before the A.N.A. endorsed what most other national health agencies were opposing.

Gaining recognition from the chair, a member of the house immediately rose and snapped, "Legislators would not be legislators if they did not take simple problems and make them complex. . . .

"Don't stay away from problems because they are complicated — get in there and simplify them," she told the delegates amidst tumultuous applause. The motion supporting the principle of health insurance in social security benefits easily carried.

Although a resolution had been placed before the house asking that the A.N.A. censure the Georgia State Nurses Association for failing to admit Negro nurses, it was sidetracked in favor of a tamer resolution that deferred for at least two more years any specific action on this matter. ■

Who Is Liable for Nursing Negligence?

SHOULD practical nurses give intramuscular injections? Assist in obtaining spinal fluid? Should professional nurses take x-rays; do laboratory analysis of specimens, and so on? What is the legal implication of who is doing what?

I think one general answer may be given. If the education or training of the nurse included the procedure and if she can satisfactorily demonstrate her competency to do the work as a result of her education or training, then it would seem she could do it where such acts are not in violation of a statute. If, on the other hand, her education or training did not include the procedure, and such knowledge as she possesses has been accumulated haphazardly, she would be well advised to refuse to do so.

But you interject, "We have no one else, the professional nurses are few and busy and the need is great — it's almost, not quite, an emergency!" "Very well," I would say to such nurse: "unless a hospital or doctor will support you in event of legal trouble, the problem will be yours alone. You will have the burden of proof to show that you had the necessary preparation and skill."

If a patient is injured through her incompetence or carelessness, the nurse is personally liable. The basis of the action is negligence with injury to the patient. The nurse must be reasonable in how she performs her work, what she undertakes to perform and whenever or wherever she performs it. All states hold the nurse liable for her own negligence. If she is an employe, her employer may be liable also.

But the nurse should remember she does not lose her liability because her employer is also liable. Employes of state or local government agencies or in states or situations where the nonprofit hospital is not liable for the negligence of its employes cannot share their liability, so the injured patient can only look to the nurse for damages. Neither can a private duty nurse "share" her liability for the hospital is not her employer. — *Adapted from a paper by Helen Creighton, R.N., associate professor, Southwestern Louisiana Institute, which was presented to the* 1960 *meeting of the American Nurses Association.*

Experts Offer Solutions to Nursing Dilemma

Recommendations of a round table on nursing include:

—Develop patterns of nursing education that fit nurses' needs

—Let nurses nurse and leave nonnursing duties to others

—Pay better salaries and broaden the salary range

—Convince nursing leaders that they need help from other members of the health team in solving nursing problems

Mrs. Martin:* 1. There must be recognition on the part of nurses, doctors and patients that a concept of nursing as held in the past is not possible or needed for the present or future.

The last 25 years have produced revolutionary changes in medical science that are reflected in nursing needs.

In the Thirties, prior to the advent of chemotherapy, improved anesthetics in surgical methods, knowledge of exact determination of physiological fluid balance, and early ambulation in concepts of rehabilitation, it was primarily a bedside nurse that was needed, one chiefly to administer to the physical needs of the patient.

Today a patient is a bed patient only during a brief critical period of his illness. During the majority of his stay in the hospital, the patient needs guidance and assistance with his physical needs; understanding and support of his emotional needs; education about his illness, and assistance with a plan of rehabilitation.

The professional nurse must be able to assess these needs and determine which of these must or should be the responsibility of the professional nurse and the practical nurse, and which can be done by auxiliary nursing personnel.

It goes without saying that the professional nurse must be able to direct the work of others.

If the doctors, patients and nurses expect that nurses will do the same kinds of things as did nurses of 25 or 30 years ago, patients' needs will not be met and the expectations of each will result in frustration.

2. Doctors, nurses and hospital administrators should work together to help the public comprehend more fully the effects that the continued shortage of nurses will have upon our society and jointly make plans and particularly scholarships for all types of nursing programs.

3. Nurses should devise an overall plan for helping foreign nurses to qualify for professional nursing licensure.

4. All interested groups, nurses, doctors and hospital administrators, should devise ways of familiarizing the public with the cost of medical services, including nursing.

5. Professional nursing organizations, universities, senior and junior colleges should develop courses to reorient nurses who desire to return to work after some years away from the field.

6. Some hospital schools should give thought to shortening their course of study through better educational practices which, if successful and effective, could act as a pattern for other schools.

7. Hospital schools should give priority to the study of their own financial situations so they and the public can more carefully evaluate the wisdom of retaining these types of programs.

8. Doctors and hospital administrators should give more thought to the plan of progressive patient zoning in order to better utilize nursing services.

9. In consideration of the large attrition rate in the first year of nursing, the thought might be given to ways of utilizing students who have completed one year of professional nursing study, perhaps by making them eligible to take the practical nurse examination in a limited area such as medical or surgical nursing.

Miss Gelinas: Let each hospital department do its own job, and get the nurse out of the middle.

Let the dietary serve the food. Let the laundry provide the linen. Let supply keep up the supplies.

Let ward administration make appointments, answer phones, order supplies.

Let maintenance change the mattresses on the bed and let the laboratory staff plan its work to fit more readily into the activities of units.

For heaven's sake, let the nurse nurse, and let the nurse supervise the

*Participants in this symposium on "Nursing Care for Patients — Dilemma 1960," presented last February by the Medical Society of the County of New York, were: Almeda Martin, director of nursing, Lenox Hill Hospital, New York; Agnes C. Gelinas, professor of nursing and chairman of the department of nursing, Skidmore College; Dominick F. Maurillo, M.D., member of the board of regents, University of the State of New York; Ralph E. Snyder, M.D., president and dean of New York Medical College, Flower and Fifth Avenue Hospital, New York. The transcript has been abstracted for publication here.

The psychological rewards of nursing are great, but today's society demands tangible rewards as well

nursing care being given by the auxiliary workers.

Dr. Maurillo: 1. Every competent degree granting two-year post-secondary institution should be encouraged to explore the desirability and possibility of offering a two-year associate degree professional nurse program.

2. Four-year colleges and universities should expand to meet the future needs for teachers in nursing programs, for public health nurses, and other specializations requiring collegiate and graduate education.

3. The facilities of the two-year and four-year collegiate institutions, especially instruction in basic sciences and general education, should be used by the diploma hospital schools for economic reasons.

4. Those responsible for the maintenance and operation of hospital schools of nursing should give immediate attention to possibilities for expansion, consolidation of extremely small units, cooperative arrangements with other hospital schools and collegiate institutions, and development of new patterns of nurse education.

5. Better salaries for all nurses are absolutely essential. Salaries should not only start higher and very much higher, but range more widely in recognition of differences in responsibilities and length of services.

6. Hospital administrations should give special attention to step-up campaigns for reactivation of nurses not so employed and for better utilization of nurse power presently employed.

7. More scholarships for R.N. training and for teacher training are needed.

8. State university medical centers should take a more active part in preparation of nurses and instructors in nursing.

9. All professional groups, colleges and hospitals should cooperate to offer refresher courses for nurses interested in reentering active nursing service.

10. Diplomate rating to nurses having recognized competency should be initiated by a professional society.

11. State education departments should assume continuing leadership responsibilities in working with interested groups on such matters as better defining nursing functions, encouraging cooperation.

Dr. Snyder: The return of nurses to nursing and the assignment of nonnursing duties to others will effectively increase the nurse pool, but more importantly will appreciably enhance the attractiveness of nursing to those who want nursing as a profession for service to their fellow men.

The rewards of nursing are very great to those who truly desire to nurse for the satisfaction it provides. But as idealistic as we may be, or wish to be, or should be, we find that today's society leaves little room for ideals alone. Certain tangible incentive rewards, m-o-n-e-y, are important aspects in today's community.

Certainly a nurse should be able to command an income commensurate with the importance and responsibility of her service, the magnitude and depth of her education and training, and the stature of her profession.

Existing developing educational patterns in nursing education taken individually have failed to meet the challenge of providing inspiring dynamic leadership in the development of a vitally important national need and resource.

Nursing education is new. In fact, it is just coming of age. It is the very newness, this late adolescence, that is so very important. It is important that educational patterns be developed that are designed for the subject rather than redesigned and remade patterns taken from other educational systems.

It must be recognized, too, that flexibility and adaptability and lack of regimentation are essential ingredients in the development of sound educational patterns.

The appreciation of these facts, however, requires more than lip service.

The three or four present-day types of programs must be strengthened, fostered and developed, for each of these programs provides a valuable ingredient to the complex responsibility known as nursing.

A lack of understanding of broad problems, narrowness of thinking in relation to multiple approaches to the same objective, excessive and unnecessary rigidity, firmness without giving has led to the development of educational patterns in nursing that individually and collectively have not met the objectives or the standards that are worthy of the importance of a position of nursing in the health team.

A broad, comprehensive program of education in the health professions and related areas must be developed. Nursing education must be designed to function effectively in a medically oriented setting and in any medically oriented setting education goes hand in hand and on an equal basis with patient care.

Opportunities must be provided for graduated educational opportunities. Current programs at all levels must be so coordinated as to provide opportunities for continual growth and development of any interested individual for higher levels of accomplishment.

The possibility and opportunity of assimilation of all nursing personnel into one professional group with specialized areas of interest and functioning must result. Great emphasis must be placed on effective teaching and the result of effective teaching – effective nursing care.

Less rigidity must be shown in terms of measuring the effectiveness of a teacher by the results that are obtained rather than by the diploma she has in her hand or the degree she has in her hand.

Degrees may be a measure of intellectual ability but never have successfully measured teacher effectiveness in any educational program.

Nurses themselves must accept the challenge, but must also recognize the fact that the assistance of other responsible representatives of the medical team is essential.

Nurses at any level need not always be the teachers of other members of the team. Nurses are only a part, albeit an important part, of the team and cannot develop broad, comprehensive interdisciplinary understanding and activity by themselves. ■

The Physicians' Review Board works with Blue Cross to reduce hospital costs by reducing overuse of facilities

Doctors Attack Overutilization

James L. McCabe, M.D.
Hugh Robertson, M.D.

THE Pennsylvania Medical Society at its 109th annual session announced a plan for community health care by self-insurance, presented with the wholehearted support of the local medical societies, Blue Cross, Blue Shield, the local hospital council, and the local insurance council.

It was stated: "The success of dealing with the increasing costs of modern medical care by voluntary group prepayment plans requires the cooperation of organized medicine with the so-called third parties in which all interested partners must concede certain privileges for the good of all."

These are strange and wonderful words to emerge from a meeting of delegates of a state medical society. The medical profession is at long last convinced that it is very much a partner with Blue Cross, the hospital association, and Blue Cross subscribers (otherwise known as patients of the doctors) in preserving free and voluntary medicine in the United States.

It is of course possible that the presence of that astute and stubborn insurance commissioner of the commonwealth of Pennsylvania, Francis R. Smith,* might have had something to do with this rather sudden decision of all interested parties to sit down and amicably work together on prepaid health problems. "I hereby prescribe," said he, in his adjudication of April 15, 1958, "that each Blue Cross plan allocate as an item of administrative expense, to be defrayed from existing reserves, a sum of money sufficient to maintain constant vigilance . . . in instituting reforms to eliminate abuses in the use of hospital care. Each Blue Cross plan shall expressly request the assistance of the county medical societies in resolving the abuses in hospital utilization. The item of expense allocated as aforesaid may be used for defraying

*Smith, Francis R.: When Hospital Costs Outrun Public Understanding — Look Out! Mod. Hosp. 94:96 (April) 1960.

The authors are co-chairmen of the Physicians' Review Board of Philadelphia.

any costs involved in cooperating with such societies in developing and carrying out methods and plans to reduce abuses."

The commissioner added tartly: "Testimony submitted in these hearings establish beyond any doubt that unnecessary utilization of hospital service can be substantially reduced by proper action and cooperation of all interested parties, including Blue Cross plans, their subscribers, doctors and hospital administrators. Any suggestion that we can't do anything about it because we don't know to what extent the abuses exist should be summarily rejected."

The Associated Hospital Service of Philadelphia conferred with the Philadelphia County Medical Society, and the Physicians' Review Board was born. The philosophy of its organization is unique; the new board was made entirely independent. It was decided that the proposed group of prominent and actively practicing doctors could only succeed in their difficult and thankless task if it were entirely free of domination and pressure from any group. At the special stipulation of the insurance commissioner it was furnished with clerical, statistical and financial assistance by the Associated Hospital Service of Philadelphia (Blue Cross).

The review board is directed by the equally divided supervision of two co-chairmen. The two-man-head plan has proved to be most fortunate; it provides divided responsibility when the going gets rough; it provides companionship in an excursion into new and strange territory; it provides constant encouragement and a chance to talk things over with a kindred spirit.

Six groups of six doctors were then chosen, each man qualified as follows:

1. He must be actively engaged in practice. He must have patients of his own, whom he personally admits and treats in local hospitals.

2. He must be well liked and trusted by his associates.

3. He must be capable of calm and objective discussion, with no axes to grind, and no grudges to irritate him.

There are 105 Blue Cross member-hospitals in the Philadelphia area. It is usual for doctors to be affiliated with several area hospital staffs; our 36 board members represent the staffs of most member hospitals; they rep-

The table shows a detailed analysis by diagnostic classification of number of cases and length of stay in member hospitals. The figures shown here indicate that in Philadelphia average stay of medical patients is one-half day longer than that of surgical patients.

DIAGNOSTIC ANALYSIS OF BED PATIENT CARE PROVIDED IN ALL MEMBER HOSPITALS — 1959

Diagnostic Classification	MEDICAL			SURGICAL			GRAND TOTAL		
	Cases	% of Cases	Aver. Stay	Cases	% of Cases	Aver. Stay	Cases	% of Cases	% of Days
A. PREGNANCY	38,969	29.5	4.8	6,388	5.0	5.2	45,357	17.4	9.9
B. NONPREGNANCY									
1. Infective and parasitic	1,797	1.9	11.0	282	0.2	12.0	2,079	1.0	1.2
2. Neoplasms	4,197	4.5	11.3	19,892	16.4	10.4	24,089	11.2	12.7
3. Allergic and endocrine	5,603	6.0	10.7	1,677	1.4	13.0	7,280	3.4	4.1
4. Blood	1,528	1.6	9.3	123	0.1	14.1	1,651	0.8	0.8
5. Mental psychoneurotic and personality	3,227	3.5	11.5	32	—	10.7	3,259	1.5	1.9
6. Nervous system and sense organs	5,590	6.0	11.5	5,996	4.9	9.0	11,586	5.4	5.9
7. Circulatory	18,731	20.1	14.7	7,106	5.9	10.0	25,837	12.0	17.3
8. Respiratory	11,142	11.9	8.8	19,968	16.5	2.5	31,110	14.5	7.5
9. Digestive	16,532	17.7	8.1	26,575	21.9	9.9	43,107	20.1	19.9
10. Genitourinary	4,913	5.3	7.6	24,697	20.4	8.4	29,610	13.8	12.3
11. Skin	2,202	2.4	10.1	3,139	2.6	6.8	5,341	2.5	2.2
12. Bones	4,235	4.5	11.1	3,271	2.7	11.3	7,506	3.5	4.2
13. Congenital	607	0.7	7.3	1,018	0.8	9.1	1,625	0.8	0.7
14. Early infancy	1,967	2.1	13.3	17	—	10.6	1,984	0.9	1.3
15. Symptoms, senility, and ill-defined	3,532	3.8	7.5	1,084	0.9	9.7	4,616	2.1	1.8
16. Accidents	7,503	8.0	7.6	6,385	5.3	10.5	13,888	6.5	6.2
Total	93,306	100.0	10.4	121,262	100.0	8.5	214,568	100.0	100.0
As per cent of C		70.5			95.0			82.6	90.1
C. TOTAL CASES (A & B)	132,275	100.0	8.8	127,650	100.0	8.3	259,925	100.0	100.0
Per cent of grand total		50.9			49.1			100.0	
Total days (A & B)	1,159,472			1,059,719			2,219,191		
Per cent of grand total		52.2			47.8			100.0	
Stay							8.5		

resent all phases of medical practice. But when they come to us they represent only themselves. We ask for their unbiased judgment and get it.

Our duties are transacted in strictly businesslike manner at regular business hours, with no night work or volunteer lassitude. Thanks to the wise stipulations of the insurance commissioner we have been able to pick the most capable men available, pay them a reasonable fee, expect them to be present at 3 o'clock on the day their group meets, and dismiss them promptly at 5 o'clock.

Members of the board meet in groups of six, once each month. The meetings are arranged so that each member knows beforehand that he will be expected from 3 to 5 p.m. on a certain Tuesday or Thursday of each month, and can plan his work accordingly. The meetings are held in very pleasant quarters in the centrally located Blue Cross building.

The meetings are conducted by the two co-chairmen, usually alternately but often jointly; both chairmen are almost always present. Secretarial, statistical and recording services are available when needed. Members sit about a large table. Before each member is a pile of photostat hospital charts, chosen for examination, as will be explained later. The subscriber contract states: (Section V11-2) "Each subscriber authorizes and directs any doctor, nurse, hospital or other institution having at any time examined, diagnosed, treated, attended, or rendered service to the subscriber, or possessing any information or records or copies of records relating thereto, to furnish to Blue Cross at any time upon its request, any and all such information or records or copies of records. Each subscriber agrees that approval by Blue Cross of coverage for any hospitalization or for services rendered under the subscription agreement is contingent upon receipt by Blue Cross of such information or records or copies of records."

The records presented to the board for examination are complete hospital records, with laboratory reports, order sheets, nurses' notes — everything that is in the hospital files regarding the patient. If the records are incomplete or inaccurate it is the fault of the attending physician, not the review board. During the first hour of the meeting each member carefully examines his group of records, making such notes as he desires and marking certain facts upon a chart for permanent business-card recording.

Physicians' Review Board in action: l. to r., Dr. Samuel Baer, Dr. Harold F. Robertson, Dr. Karl C. Jonas and Patricia White (secretary) confer with Dr. Hugh Robertson and Dr. James L. McCabe, co-chairmen of the board.



The second hour of the meeting brings a group discussion of the individual records. Each board member, in turn, discusses each of the records he has reviewed, but *the name of the patient, the name of the attending physician, and the name of the hospital are not divulged.* Board members have been briefed on the provisions of the subscription agreement. Certain important terms and provisions have been printed upon large cards for ready reference. A general discussion then ensues. The question is asked: "Is this patient entitled, by the terms of his written agreement with Blue Cross, to payment for this trip to the hospital?"

A vote is taken. If the board decides that the hospitalization was not in keeping with the terms of the Blue Cross agreement, the Association Hospital Service is advised not to pay the bill. Often the board decides that the hospitalization completely fulfilled the requirements of this contract, and advises payment of the bill. Blue Cross has never questioned one of our decisions; attending physicians frequently do. Disputed decisions are presented to a second or third group for discussion. The hospital record is again reviewed and the protesting doctor's letter is read anonymously.

It is important to record that no Blue Cross official is present at any meeting except by special invitation, and that all discussion and decisions are made by doctors actually engaged in active medical practice.

In addition to this review of questionable current cases our board also is engaging in the study of a series of old records selected because the last two digits of their subscription numbers were 79. In these older cases we are particularly interested in overstay, overutilization of facilities, delay in scheduling or obtaining services, and so forth. We hope in this way to obtain a statistical survey of the frequency of abuse. Frankly, however, we are more interested in finding and in correcting abuse where we find it in current cases.

Before the Meetings

Much of the activity of the Physicians' Review Board, and the benefit that will accrue to our community by its action, is dependent upon a great deal of preliminary work by a lay staff that has been accomplished before the doctors assemble. Hospitals must be visited, records located, photographed and arranged. While it is true that Blue Cross could not possibly do what this organized group of doctors is doing, it is equally true that without Blue Cross the Physicians' Review Board would be just another committee to draw up high and lofty resolutions.

Here, at long last, is a group of mature and capable doctors, encouraged by the good wishes of a community prodded on by commonwealth government, and endowed bountifully by Blue Cross with clerical help, statistical and mechanical

assistance, telephone, office space, and funds for necessary expenses. This conjugation of the planets may never occur again. We plan to make the most of it.

For years Blue Cross has been paying hospital bills it felt were not in accordance with the terms of its subscriber agreements. It tried at first to have a medical director pass upon the validity of certain claims, but his objectivity was openly and loudly protested. He was an insurance company employe and had no practice of his own — and that was that. An attempt was made to have an official committee of the local county medical society do the work; this failed. Next Blue Cross tried sending questionable cases to "medical referees." That didn't work. Then came deficits and public rate hearings and a general demand that something must be done about questionable hospitalization claims.

During all this time capable and experienced Blue Cross employes were processing hundreds of claims that they wished some capable and interested doctors would or could check. When a bill first comes in for payment one can never be sure of its implications; only a review of the complete hospital records will give a satisfactory picture of the hospitalization. Many of the records for the review board come from the experienced hands of skeptical processors. The questioned hospital bills are sorted by the co-chairmen. Those deemed worthy of further study are listed and Blue Cross employes go to the hospitals and make photostatic copies of the complete hospital record.

These records are then inspected by the two co-chairmen; some bills obviously should be paid, others are questionable and are submitted to the board for decision. This, then, is how the stack of hospital records get on the table of the review board.

But Blue Cross facilities enable the review board to contemplate much more than this. Modern computing machines produce statistics and charts to permit comparison of similar groups of patients from hospital to hospital. When this is done interesting variations crop up. Records of such groups of patients are obtained and reviewed by the board. An example of such a statistical study showing diagnoses and length of stay for all hospitals in our area is appended to this report.

All of this requires much assistance, much time, and is very expensive. Without this premeeting activity the Physicians' Review Board could not function.

After the Meetings

The board has met, has reviewed a group of hospital charts, and has made decisions regarding them. The board members have done their work; they have no compunctions regarding their judgments for they had no knowledge of the identity of those they have criticized. It has been said that too often audit committees are junior staff members — the junior surgeon audits surgery records, the junior medical man audits medical records, and so on, and all are afraid of professional reprisals by seniors. We do not have this difficulty; our board men are all seniors, and because we review the records anonymously, do not know whether the scrutinized doctor is a personal friend

(*Continued on Page* 162)

What Doctors Can Do To Help

RECENTLY, all registered physicians in the Philadelphia area were sent a folder entitled "Important memorandum to physicians, the Physicians' Review Board of the Associated Hospital Service of Philadelphia Earnestly Seeks Your Cooperation."

The folder stated: "There are numerous things that we, as practicing physicians, can do to make voluntary insurance more attractive and efficient, thus lessening the pressure for inefficient compulsory government insurance. No one from Blue Cross ever expects a doctor to put its interest above the welfare of his patients. Nor does Blue Cross ask you to interpret an insurance contract, to act as a policeman, or be an insurance agent. Still, there are a few very helpful things you *can* do. They are:

"1. When a patient says 'I have Blue Cross,' tell him he is very fortunate. (He really is.)

"2. If he needs diagnosis, but not actual bed-care, say: 'These studies do not require you to stay in the hospital overnight. They can be done just as well in the hospital laboratory or in Dr. Smith's office. If you want to be admitted to the hospital for this work you should realize Blue Cross does not pay your bill, unless you have a very special contract. Why don't you ask Blue Cross first, and then there can be no misunderstanding.'

"3. Please see your patient and write orders immediately after admission. Do not admit a patient for his or your convenience and expect Blue Cross to pay the bill. Discharge promptly when it is safe. Length of stay is a vital factor affecting Blue Cross rates. Reducing average stay one-half day would save more than $3 million a year.

"4. Be kind but firm with the patient who expects you to help him abuse Blue Cross through the unnecessary admission, overprescribed services, delay in discharge.

"5. In short, in every practical way at your disposal, lead the patient to understand that Blue Cross coverage does not mean a carte blanche license for costly, unnecessary services which eventually must work to his disadvantage.

"6. Bear in mind that clear and concise admission and discharge notes signed by attending physician will help the Review Board make a fair and accurate analysis of the case.

"7. Make best use of the little booklet, 'A Word From Your Doctor About Blue Cross Coverage.' Its distribution in quantity assures a patient he is not being singled out for special warning."

With the folder to the doctor was enclosed a copy of this booklet intended for distribution to patients to assist him in explaining the Blue Cross agreement in terms the patient can understand. ■

Success of its first circular unit has led

this hospital to construct a second one

to meet the demand for additional space

Round Hospital Moves Into a New Circle

ONE of the first circular hospitals to be built, Valley Presbyterian at Van Nuys, Calif., created quite a controversy in hospital circles.

Featured as The Modern Hospital of the Month in the March 1957 issue of this magazine, the structure was criticized on various grounds. Specifically, consultants questioned the circular nursing units in which patient rooms were arranged around the perimeter facing the nursing work area; the somewhat cramped work area in the center, and the feasibility of expanding a 63 bed hospital to 400 beds without disruption of service, as proposed by the architects, Pereira and Luckman of Los Angeles.*

At the time these and other questions were raised, the hospital was still under construction and the practicability, or otherwise, of its features had not been tested. The first phase of the hospital has now been in operation for two years, and the second phase, a four-story, 120 bed addition, is in preparation.

Reviewing the two years' experience with the 63 bed unit, the architects and hospital officials agree that, in general, the design has proved successful, although the architects state that "several improvements are being made on the original nursing unit, based on the experience of the hospital staff."

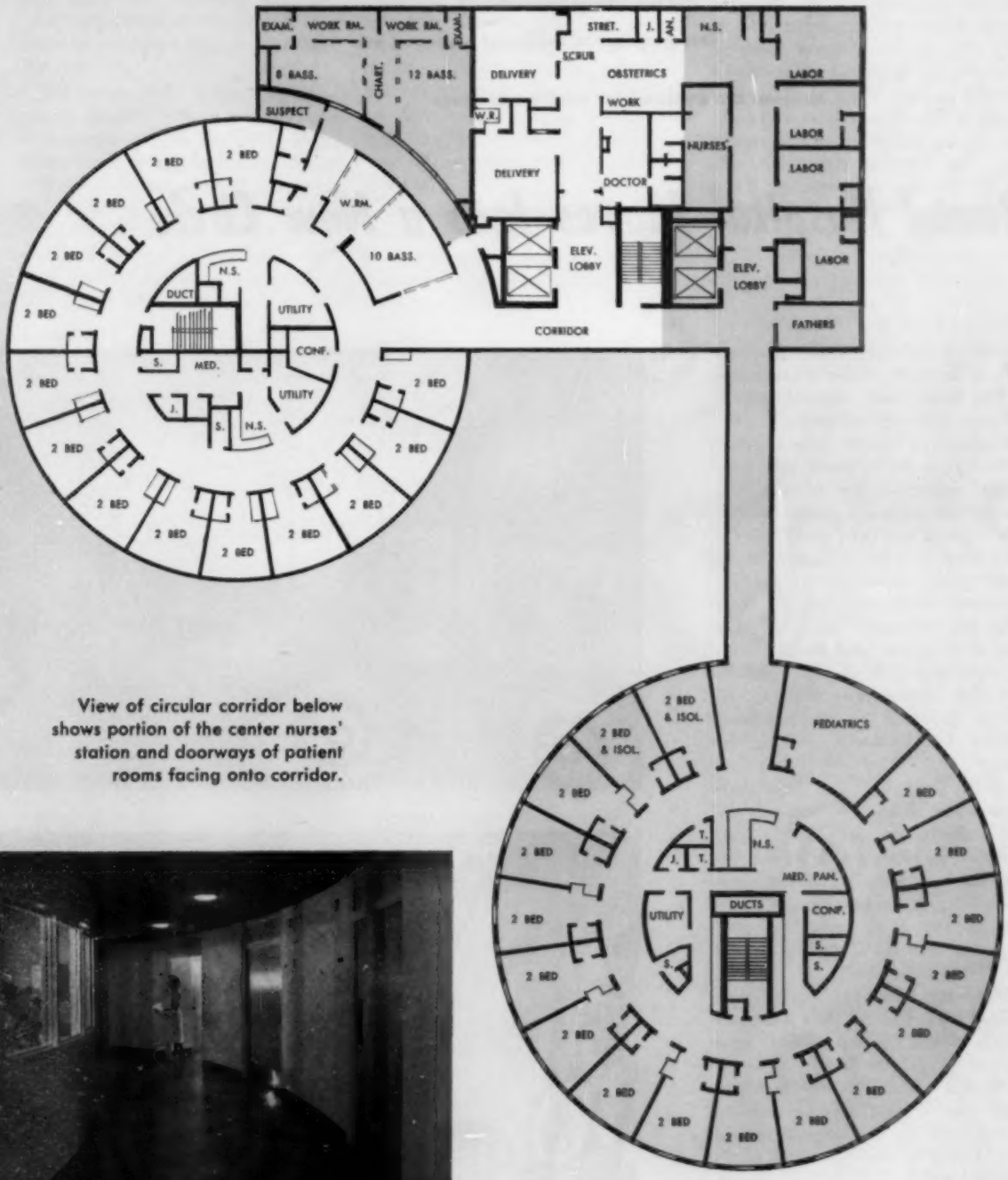
On the following four pages are presented some of the objections raised by consultants when the first unit was proposed, together with a discussion of how each of the controversial features has worked out in practice. ■

*The new addition has been designed by Charles Luckman Associates, Los Angeles, successor to the firm of Pereira and Luckman.





Circular design of Valley Presbyterian Hospital, Van Nuys, Calif., (top) stirred considerable controversy. The second phase is shown in rendering above.



View of circular corridor below shows portion of the center nurses' station and doorways of patient rooms facing onto corridor.

Shaded areas in plan show how new circular addition will be attached with connecting service and work areas.

CIRCLE DESIGN LETS NURSES CARE FOR ADDITIONAL PATIENT LOAD

What Critics Objected To

The circular unit can't be expanded. Further expansion of the nursing units will be precluded by the design. Additional nursing units cannot be added vertically because of the air conditioning equipment penthouse. Any additions would disrupt existing services.

Cost of construction is too high. A circular building is more expensive to construct than the conventional rectangular shape.

Nursing work area is small and cramped. The nursing station and associated work areas are crowded, cut up, and will hamper the nursing staff.

Location of rooms, beds is unfavorable. Only a few rooms are oriented to give patients a good exterior view. Position of the beds (perpendicular to exterior wall) forces them to look at nurses' work area. Nurses have limited observation of patients' rooms.

How They Worked in Practice

Expansion into the second (120 bed) phase of the program has been very easy, without disruption of the hospital's day-to-day operations. The administrator, Henry X. Jackson, explains that a second tower of four floors (instead of the three originally planned) will provide the additional bed capacity. Each floor will be increased to 40 bed units instead of 34 beds, as in the original unit. "The efficiency of the circular design, plus a decided increase in the architects' predicted savings of 37 per cent of nursing 'mileage,' allows us to take on these additional facilities and extra services with considerable improvement in our operating budget," Mr. Jackson states.

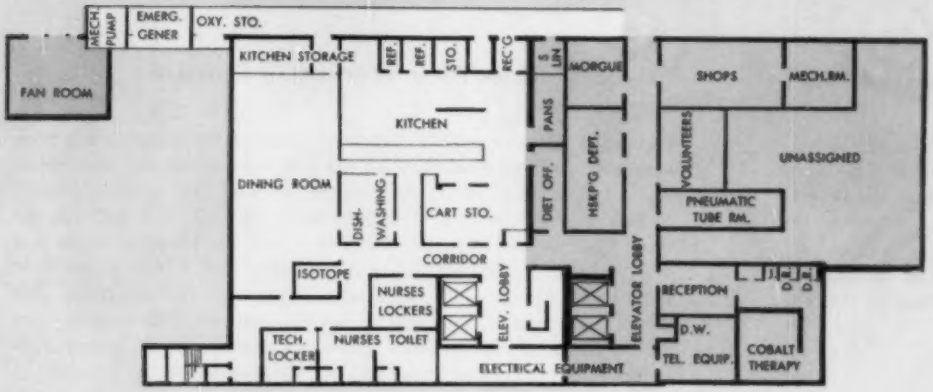
Valley Presbyterian Hospital had the lowest construction cost per bed of any Hill-Burton project of similar size under construction in California during the time it was built, according to hospital officials. The building cost per bed of the second unit, it is estimated, will be still lower because many of the service facilities provided for in the first unit were designed to accommodate 100 beds. Cost per bed in the second unit, including Group 1 equipment, is expected to be less than $14,500 per bed as compared to $18,300 per bed in the first unit.

The central work area in the core of the nursing unit has proved in practice to be a bit cramped, Mr. Jackson says. However, he adds, since the hospital plan is expandable, to be built in several phases, this fault can be remedied by enlargement of this space in the second nursing unit. Edith J. Evans, director of nurses, points out that experience has shown that the present nursing staff could easily handle six additional patients in each unit and has recommended that nursing units in the new tower be increased accordingly. The central nursing core is both a convenient and efficient means for the nurses to provide better care to patients, in the opinion of Dr. Charles B. Canby Jr., director of the medical staff.

Thus far, no patient has complained about the orientation of his room, Miss Evans reports. Design of the rooms to give each patient a window of his own has eliminated the problem of moving a patient because he wants to be near a window. Nor has locating patients' beds on the outer wall so that they face the nursing work area proved to be a problem, for either nurses or patients, she adds. "We have found that this arrangement allows us to observe the patients constantly as we make our rounds. We find, too, that the patients actually enjoy observing the corridor activities." (See also comment of a patient on page 107.)

(Continued on Next Page)

Shaded areas indicate how a portion of service building is being expanded to accommodate many of those services that have no direct contact with patients or staff.



SECOND PHASE OF CONSTRUCTION WILL ELIMINATE INCONVENIENCES

What Critics Objected To

Ancillary facilities are inadequate. Both diagnostic and darkrooms of x-ray unit are crowded. A toilet should have been provided for emergency patients. Kitchen should have separate dishwashing area.

Traffic flow takes supplies through lobby. Soiled supplies from floors above, as well as new supplies delivered to floor below, arrive by elevator and are carried through lobby to receiving end of central supply.

How They Worked in Practice

The kitchen is being expanded to serve three times the volume of meals by the addition of a few pieces of equipment, extension of the serving line, and provision of additional dishwashing facilities and cart storage, the architects explain. The adjacent storage area is being converted into a dining area. It is Mr. Jackson's feeling that the second phase of construction, when it is completed, will eliminate some of the inconveniences the staff has been living with, such as not enough x-ray facilities, shortage of laboratory space, lack of separate dishwashing area, and the necessity of transporting patients through public areas to get them from surgery to the nursing units.

Two additional elevators are being provided in the new wing. They will permit the original elevators to be devoted entirely to service functions, as was originally intended, and let the new elevators handle the visitor traffic, Mr. Jackson states. Operation of the new elevators will also eliminate cross traffic on the service floors. ■



Nursing director, above left, is busy checking with one of the doctors from the compact nurses work area.



PATIENT LIKES TO BE IN THE CENTER OF THINGS

Patients don't mind looking at the nursing station; in fact, they rather like it, according to Loretta Preimesberger, a patient (see picture at left) who was asked to comment on perimeter placement of the rooms.

Mrs. Preimesberger's reaction was: "I'd prefer to have my back to the wall because it cuts out the glare. Besides, if I really want to look out the window I can easily do it by turning on my side. Even though the view from my window is quite pleasant, I'd rather look into the corridor and watch what is going on there. It gives you a feeling of being a part of it, whether you are or not. You get away from that feeling of being almost forgotten, that you have when you are near the end of the hall as in some of the more conventional hospitals."

Nor did Mrs. Preimesberger object to the "austerity" of the room from which both blinds and draperies have been banished because they are dirt collectors. She liked the simple decorations and soft colors used in the room and didn't miss the draperies. ■

Above right: A patient expresses satisfaction with perimeter room. Right: Entryway doubles as lounge.





Only exterior panes of double-glazed windows in Baptist Hospital were damaged after 30 minutes' exposure to 1200 F. heat during fire raging across the street.

Prayers Instead of Panic

Baptist Hospital Survives Its Baptism by Fire

MEMPHIS, TENN.—Double-glazed windows in the Madison-East unit of Baptist Memorial Hospital here withstood 1200 degree temperatures for 30 minutes during a roaring fire which destroyed a baseball park across the street and threatened to engulf both Baptist and the John Gaston Maternity Hospitals April 17.

The dual pane windows, with a cushion of air between the panes, were credited by Frank Groner, hospital administrator, and Edward E. Hamilton, acting chief of the Memphis fire department, with saving the building. "Without those windows," Chief Hamilton stated, "we would have had a bad situation. As it was, the curtains got so hot in some of the rooms that nurses couldn't touch them to pull them down."

These windows had been installed throughout the 12 story building except on the first floor, where the conventional single-pane glass — in Mr. Groner's words — "didn't last two minutes." The outer glass on the double windows cracked but didn't break, and the heavy aluminum frames with double rubber fabric weatherstripping held the panes in place. Virtually all the damage to the interior of the building was confined to the first floor, it was reported. Carpeting and draperies on this floor were destroyed and some furniture was damaged.

Around the corner at John Gaston Maternity Hospital, 24 single-pane windows exploded from the searing heat and flames, and the window frames caught fire. There was no damage to the interior of the hospital, however, which for a time seemed to be in greater danger than Baptist Hospital. A human chain of doctors, nurses, medical students, and other volunteers removed 68 infants from the Gaston nursery to temporary quarters in the children's wing of the hospital.

Disaster training of employes paid off in both hospitals. At Baptist, 250 patients were removed from the endangered area in about 15 minutes, Mr. Groner stated. "It was a very orderly operation and there was no real panic among the patients," he said. To which a nurse added: "There was no time for panic; everybody was too busy praying."

The patients, who, according to Drexel Toland, assistant administrator "took the fire better than anyone else," were moved to rooms and corridors on the south side of the building and to a section of the old building that was undergoing renovation. Many patients walked to elevators or down several flights of stairs. One patient, who was recovering from major surgery, walked down seven flights of stairs without apparent ill effect. "When the nurse came in and snatched the curtains away to keep them from catching fire, I decided it was time to leave," he commented.

Other hospitals in the area, although not threatened by the fire, went onto emergency status and called employes back to service to help care for patients from Baptist and Gaston hospitals if it proved necessary. "The way individuals and other hospitals pitched in to help was impressive tribute to the volunteer way of doing things," Mr. Groner stated.

FIRE SAFETY PLANS SHOULD INCLUDE THE EXTERIOR

THE Memphis fire which threatened Baptist Memorial and John Gaston hospitals indicates that double layer glass has value as a fire retardant. The danger at Baptist Memorial was mitigated because the windows facing the fire exposure were double layer with an air space between the layers.

Glass has been used successfully in fire protection since 1893 when machinery and processes were perfected for the manufacture of wired glass.

Although the standard requirements for wired glass recommend its use in moderate or light exposure, it has stood up well under more adverse conditions. With a double retardant, and here again is the layer with air space principle, it is strongly recommended for severe exposure.

Adjoining frame construction and hazardous use occupancies constitute severe potential exposure. Distance is important. Twenty feet, 10 feet or 5 feet separation of lot lines from severe exposure become progressively more hazardous in that order, and one man's fire can easily become another man's problem.

It must be remembered that wired glass does not prevent the passage of radiated heat. In other words, the glass can remain intact against radiation, but combustible building contents are not equally immune.

From the standpoint of exposure, it is imperative that combustible material in a building be kept well away from exposed windows. Three-foot clear aisles should be maintained along all exposed walls. Contents and stock should not be piled higher than a man's reach. Clear aisles should be maintained at right angle to all windows to provide accessibility for quick window closing, and for firefighting.

Radiated heat under still air conditions has ignited combustible building trim as much as 500 feet away. In major fires the invisible heat which travels high and ahead of the fire will ignite combustible material as far away as several thousand feet.

In order to spread and cause other fires, a fire in progress must have opportunity to do so. This is provided by the failure to safeguard surrounding property, or by using flammable material for construction or roof coverings. Brick or concrete construction will resist fire, but if the openings in walls are not properly safeguarded, fire can enter a building. Even where wood construction is used, proper protection is of great material help to fire departments.



Fanned by high winds, flames from ball park leap across street and threaten Baptist Hospital.

Experience at Memphis should be incentive enough for all administrators to resurvey and re-examine all exposure conditions at wall, roof and window openings. Although much time and thought have been devoted to planning for interior fire safety, it might prove both timely and sensible to study outside threatening possibilities in order to provide adequate protection against such sources. — LT. ROBERT MCGRATH, *consultant on hospital fire safety and former hospital inspector, Chicago Fire Department.*

Participants at fire drill institute at Doctors Hospital, held two weeks before fire, watch evacuation demonstration.



This was no fire drill; it was the real thing. The dedication day blaze damaged original part of the hospital.



Hospital Prepared for a 'Hot Time'—

William S. Konold and Richard L. Sims

WHEN fire plans are in the preparation stages and fire drills are being held, there exists a general feeling among hospital employes that it "surely won't happen here."

Well it can happen here – and did. In our case, it happened Nov. 12, 1959. But the story begins long before the cry of "fire!" If it had not, this account could never have been written.

From its very beginning Doctors Hospital in Columbus, Ohio, had a fire plan of sorts and had "gone through the motions." However, our plans did not provide the protection we wanted and we were concerned.

First step taken by the administrator to remedy the situation was the establishment of a fire committee consisting of key department heads.

The fire plan in operation was reviewed and revised by the committee. Several classes on fire extinguisher use were held immediately, and semi-annual "practice sessions" were established. Informal sessions were held with each department head concerning the fire hazards peculiar to his department.

Inspection reports by the Columbus Fire Prevention Bureau were studied carefully and recommendations were put into effect. The hospital house organ was used to keep employes fire conscious, as was the information bulletin board.

Even with these customary steps taken, the committee felt the job was not yet completed.

It was decided that the next step should be a general training institute to cover all phases of fire preparedness. The cooperation of the state fire marshal's office was enlisted and steps were taken to establish a one-day program on October 28.

Because it had been several years since a coordinated program of this nature had been conducted in a Columbus hospital, it was decided to invite interested personnel from other city hospitals that constitute the Columbus Hospital Federation. More than 100 hospital representatives were on hand for the eight-hour training session.

Louis A. Helmke, a fire prevention specialist with the Ohio fire marshal, provided most of the instruction. Main emphasis of the lectures and demonstrations was on providing simple practical methods in fire control and removal of patients. They gave instruction on what to do when a fire broke out and how to use materials at hand to control fire.

Actual fires were set in beds and waste cans to provide realism in prac-

Mr. Konold is administrator and Mr. Sims is director of public relations of Doctors Hospital, Columbus, Ohio.

Firemen remove hoses used to control fire. Note badly blistered paint.



Six Ways To Minimize Effects of Fire

1. Be prepared. Have a fire plan and practice it.

2. Be adequately insured. The entire loss of our hospital fire was taken care of by our fire insurance program.

3. Never underestimate the gallantry or ability of your fire department or the importance of its recommendations.

4. Have faith in human nature. You can count on your department heads, personnel and friends to perform beyond your greatest expectations in an emergency.

5. Take the time to keep the news media properly informed.

6. Keep calm. Your placid attitude in a disaster rubs off on everyone.

and the Preparations Paid Off When It Came

tice sessions. Hospital personnel acted as patients for evacuation purposes.

Even the public relations value of the program was not forgotten in the planning. A half page picture spread followed the institute in the Sunday edition of the largest Columbus newspaper. Ironically the caption for the story was: "Hospital Prepares for a Hot Time."

Doctors Hospital had planned an elaborate program to commemorate the completion of a $2,500,000 building and expansion program. Formal dedication ceremonies were scheduled for Sunday, Nov. 15, 1959.

Thursday prior to dedication was to have honored hospital employes for their years of service. All "family members" were anxiously awaiting the special events planned for the day as they arrived for work on November 12.

At about 8:30 a.m., outside construction workers who had been called in to finish some pipe insulation work discovered a loose pipe connection. They called for the maintenance men to sweat the two pipes together with their welding equipment.

As the workers entered a tiny crawl space in the switchboard room between the ceiling of the first floor and the floor of the second, the insulation men moved a few feet away with their equipment. The torch was lighted.

Suddenly there was a "whoom" as the torch ignited fumes in the crawl area. Flames immediately concentrated in a gallon can of liquid adhesive which had been moved several feet from the work area. One worker who had moved further back in the crawl space was virtually trapped with the fire between him and the exit.

Fast thinking by the maintenance man who grabbed the can with his gloved hand and removed it from the crawl space was credited with saving the life of the insulation worker. By the time the burning container had been removed from the small area, the worker's clothes were on fire and it was immediately evident that the can must be disposed of. Seeing a window, the maintenance man threw the can. Unfortunately his aim was about 2 inches off and the container smashed against the window frame and bounced back into the room, spreading flame throughout the area.

Instantly the blazing liquid hit other workers and the switchboard operator. Automatically, she plugged in the information desk phone to an outside line and ran to the adjoining room to call the fire department. With her uniform ablaze she crashed through a glass door and stumbled to the telephone. (*Cont. on Page 166*)

Regional Meeting Speakers Talk of Many Things, But They All Come Back to Labor and the Aged

IF THE conversation and programs at this year's regional hospital conferences are any indication, hospital administrators across the country are suffering from severe labor pains.

Most meetings featured sessions on personnel policies, although occasionally they were hard to identify, as in the case of one regional meeting that called its assembly on this subject "Running a Happy Ship." Whatever their titles, the sessions on this subject were generally well attended, and in lobbies, in the aisles of exhibit halls and, occasionally, at the poolside, chief topic for debate and worry was how to prevent union demands for recognition and how to handle them when they showed up, as they were doing with increasing frequency. In Los Angeles, Miami Beach, Minneapolis, Chicago, Kansas City, Roanoke and Atlantic City, experts and second guessers had their say on this subject. When they did agree it was on the need for hospitals to develop enlightened personnel policies and tell their employes about them in a hurry.

Sharing equal billing at most conventions was another troublesome area: The problem of financing the health needs of the aged. Here the convention planners could not have been more timely. Conventioners had the heady experience of finding their problems in this area argued on the front and editorial pages of the daily press and in Congress, where bills and counter-bills were being introduced at the time of the regional meetings (see *p.* 77).

Reports and comments on these and other key issues examined at the regional meetings appear in adjoining columns and on pages 172 and 174.

Labor Problems Are Heading South, Speakers Tell Southeastern Conference

MIAMI BEACH. — Like bad weather, labor problems are something the South prefers to leave up North, but there seem to be more than enough of them to go around, speakers at the Southeastern Hospital Conference pointed out here last month.

"Labor leaders report a marked acceleration in their organizing efforts across the country," according to Carl Flath, a New York hospital consultant. Like it or not, he said, collective bargaining is now "an unavoidable facet of hospital administration."

Mr. Flath described the 46 day strike against New York hospitals last year as "a clear-cut victory for the union." The strike, he said, "left the union relatively free to move in again almost at will."

If nothing else, Mr. Flath observed, unions are making hospitals pay attention to their personnel policies. He said that a survey of personnel practices in New York hospitals showed wide variances in benefit structures and a "general absence of written, clearly stated, easily understood personnel policies available for and interpreted to employes." Many hospitals surveyed, he said, did not provide pre-employment or periodic physical examinations or sick call clinic service for employes, an oversight he characterized as "stupid."

Union activity in southern hospitals will undoubtedly increase, and exemption of hospitals under the Taft-Hartley Act may lull some of them into a false sense of security, Kirk M. McAlpin, an attorney from Savannah, Ga., suggested to the assembly. Organized labor, he said, loves nothing more than "a complacent management." Protection by laws, he noted, will not prevent employes from wanting to organize if working conditions are unsatisfactory. One of the best ways to avoid employe dissatisfaction, he said, is to "sell the hospital to employes." Let the wife of the employe as well as the employe understand that the hospital is a good place to work, he emphasized. For example, he suggested, send notices of pay increases in writing to employes' homes and perhaps include a message summarizing some of the other benefits and status rights employes earn by working at the hospital.

Hospital immunity from tort liability is disappearing rapidly and its future "may be measured in years rather than in decades," Alanson Willcox, legal counsel of the American Hospital Association, told his audience.

"As you teach the public to expect more and more from their hospitals," he said, and "as you enable them through prepayment to convert their care from a matter of charity to a matter of right, you must expect the moral responsibility which hospitals

have always accepted for the safety of their patients to find increasing expression in legal accountability for errors."

Noting that "professional liability and patient safety are two sides of the same coin," Mr. Willcox said that "professional and administrative people should be tagged with the over-all responsibility for patient safety.

Notice was served by the American Hospital Association that it does not intend to stand pat in the present and continuing hassle over nursing school accreditation. Although he said he was "quite encouraged" over recent developments in this area, Frank Groner, A.H.A. president-elect, warned that if the present accreditation procedures could not be adjusted to provide a fair voice for hospitals in this program, the association "will have to provide another mechanism – and," he added ominously, "it will."

Mr. Groner, who is also administrator of Baptist Memorial Hospital, Memphis, said that the current state of negotiations between the National League for Nursing and the American Hospital Association over the nursing school accreditation program had been accurately summarized by Dr. Stewart Hamilton, chairman of the A.H.A.-N.L.N. Interorganization Committee, as follows: "We got less than we wanted – but more than the National League for Nursing wanted to give us." ■

Care of Aged Is Job for Private Insurance, A.M.A. Officials Tell Middle Atlantic Group

ATLANTIC CITY. – The American Medical Association still believes that "if given a chance, private health insurance would be able to handle the problems of the aged," a spokesman told hospital administrators here April 28.

Dr. F. J. L. Blasingame, executive vice president of the A.M.A., told delegates at the Middle Atlantic Hospital Assembly meeting here that labor leaders are trying to "stampede" Congress into "hasty and dangerous" action on an old-age health program.

Support of this stand from an economic standpoint came, naturally enough, from Arthur Kemp, director of the A.M.A.'s economic research department. In his address to the delegates, Mr. Kemp said a reason that is "seldom stated explicitly" for support of government regulated health care is the "desire to use the health care mechanism at least in part as an egalitarian instrument for the redistribution of income."

An implicit assumption of this position, Mr. Kemp said, is that "an individual should not be required to provide for his own needs or wants," but that items of "real significance, such as his life, his old age, his health, or the life or education of his child, ought to be paid for by somebody else."

He concluded that at the bottom of most arguments against a system of voluntary health care "is a lack of belief in freedom itself."

New methods and increased automation are helping New Jersey hospitals hold down costs in nonprofessional departments and thus, in part, moderate the effect of improved and more expensive medical services, the speaker said.

J. Harold Johnston, executive director of the New Jersey Hospital Association, reported on the recently completed study of 18 "typical" general voluntary hospitals in New Jersey. He pointed out that only slightly more than one-third of the over-all 32 per cent increase in per patient day costs was attributable to nonprofessional departments, such as administration, dietary, housekeeping, laundry and plant operation.

During the five-year period covered by the study, the average per patient day expense of these departments increased only 21 per cent.

On the other hand, the average per patient day costs of professional departments jumped 41 per cent, or almost double that of the nonprofessional departments. This, according to Mr. Johnston, is a natural reflection of the improved medical care and the increased number of diagnostic, medical and surgical services offered in New Jersey hospitals.

(Officers of the three state associations that met here are on page 178.)

Carolinas-Virginias Delegates Get the Word From Machiavelli

ROANOKE, VA. – A new addition to the bookshelves of successful hospital administrators came highly recommended at the Carolinas-Virginias Hospital Conference by Norman H. Martin, professor of sociology at Michigan State University.

Professor Martin suggested that hospital administrators who want to get on with their careers could do far worse than follow the example of Machiavelli's "The Prince," a sort of 15th century manual on how to lose friends by influencing people.

Providing some Twentieth Century tips on how to do this, Professor Martin said that administrators must learn to plan their moves – "anything else is stupidity."

Executives, he emphasized, must understand what is going on around them, develop "a grapevine," and learn how to make "a joint use of fear, praise and respect."

To be successful the administrator must learn how to help people save face. He must make sure that "others get blamed" and he doesn't, so that he can save his "role as a leader," according to Professor Martin.

Earlier at the meeting, some tactical moves that administrators might use to combat union activity in hospitals were presented by William I. Christopher, director of hospital personnel services of the Catholic Hospital Association.

Mr. Christopher ironically observed, "there is not one thing which unions can do for hospital employes which hospitals can't do voluntarily." Yet, he said, some hospitals appear to be dragging their feet in this area. "Hospitals should stop studying only their assets and begin to look critically at their liabilities. Lack of modern, realistic personnel programs is helping unions get into hospitals," he pointed out.

Improved personnel policies, however, are expensive, he warned. In some hospitals, Mr. Christopher predicted that costs would increase 14 to 15 per cent in 1960 over costs in 1959 as a result of union pressures that led to increased benefits for employes.

The hospital field is still fair game

(*Continued on Page* 180)

Special department meets special needs

of young people at the in-between age

Teen-Age Unit Makes Life Easier



Teen-age patient learns to weave a tie with help from an auxiliary member. Crafts and games, such as the checkers being enjoyed by two youthful patients shown on the cover, are available to help the teen-agers pass their time.

for Patients, Parents and Staff

Paul R. Hanson

TEEN-AGERS have peculiarities and their own ideas of how life should be. When they are ill, they're still entitled to have some of these idiosyncracies catered to.

In the last decade or two the world, excepting hospitals, has more or less caught up to the fact that these young people, neither children nor adults, demand and hope for understanding and respect. **Yet it is only in a small handful of hospitals that the adolescents have finally achieved teen-age departments — and a new measure of understanding and consideration.**

Their special needs became particularly apparent to me in the summer of 1955, when my young son, then near the end of his 13th year and scheduled to be a high school freshman in another month, suffered an accident which required about three days of hospitalization. As he was 13, he was automatically placed in the pediatric department. As a normal boy, he was experiencing the usual conflicts of his age and craving recognition as an adult rather than a child. He was incensed and embarrassed.

This personal experience led me to wonder if perhaps there were peculiar needs of this age group that we were not meeting when hospitalization is required. The usual pattern of most hospitals has been to put those under 14 in the pediatric department, those over 14 in adult wards. So we looked into it, conferring with the admitting office, members of the nursing and medical staffs, and even parents.

The experience with one patient alone, a girl who had required six periods of hospitalization between her 14th and 17th years, was both disturbing and valuable to us.

Her mother wrote us:

"Four years of now-and-then hospital care for our daughter has given us time for observation, criticism and understanding. . . . I am pleased that I can explain how my husband and I feel about a long-needed place for these young people . . . too old for pediatric departments and too young to become a part of the adult world of illness.

"These young people are no longer children, but they are facing their own emotional maturing years. Must they be faced with more than necessary griefs and worries?

"Four years ago our daughter started what has proved to be a long siege of hospitalization . . . this trip was for observation, including any emotional nervousness. Her youngest roommate was the mother of a 20 year old girl. The oldest was past 60, expiring from a heart ailment. Two days later we managed to have Suzie moved, and we tried to forget those first days.

"A year later she was back. After two weeks in a room with an older patient who refused to speak to her the entire time, she was moved to a four-bed ward."

The mother wrote that all three of the older roommates were in for gynecological care, including hysterectomies, and were filled with great "can you top this" stories of diseases, surgeries and curiosity about others.

"For a child to live with these strangers' morbid questions and stories while she is fighting her own fears and questions is tragic in itself," she said.

We came to realize that as a hospital we had totally ignored the requirements and problems concurrent with youth — psychologically, sociologically and even nutritionally.

Fortunately, the solution was rather simple. To any hospital administrator, space is the first problem. At Emanuel, which now has 448 beds, plus 106 bassinets, we completed an extensive remodeling and expansion program in early 1955.

Our old surgical suite was on an abbreviated top fifth floor. We moved this to a lower floor to facilitate the



Paul R. Hanson has been administrator of Emanuel Hospital, Portland, Ore., since 1947. Formerly, he was administrator of Iowa Lutheran Hospital, Des Moines, and St. Luke's Hospital, Fergus Falls, Mont. He is a past president of the American Protestant Hospital Association, Iowa Hospital Association, Oregon Association of Hospitals, and of the board of trustees of Hospital Service, Inc., of Iowa. Mr. Hanson is a member of the American College of Hospital Administrators.

handling of patients. A new top floor connecting wing was to be a pediatric department, and it had been decided to remodel the old surgical suite to serve as an admitting and isolation area for pediatrics, with about 18 beds and service facilities there, to be part of the 67 bed pediatric department. Because the section was to be for pediatrics, we used the same type of construction, with window lights to the hallway.



Corridor traffic is often heavy as the teen-agers enjoy visiting — and the boys find the "scenery" so pretty.

Pediatrics was a new service for our hospital, and we had miscalculated the bed requirements. The new wing alone proved sufficient, without the remodeled surgical suite.

Here we felt that perhaps we might experiment with a teen-age department. We drew up plans, policies, rules and regulations, and carefully picked the nursing staff. First patients were admitted in October 1957.

Common sense and recognition of the peculiar problems of teen-agers dictated the rules for us. We found that the teen-agers liked the windows to the hallway. They liked to know what was going on all the time. But we also installed draw draperies over the hallway window lights and completely around each bed to provide the privacy also required by this age group.

The fact that the teen-age department is adjacent to the pediatric department also provides for flexibility in the assignment of personnel. The pediatric supervisor doubles in responsibility by serving as supervisor of the teen-age department. By serving as such, she has the authority to utilize personnel of both sections to the greatest advantage as the census fluctuates.

All teen-agers, 13 through 18 (unmarried), are admitted to the teen-age ward, regardless of illness. In addition, certain others can be assigned by doctors, depending on maturity and needs. We have had some mature 11 and 12 year olds, and some babyish 20 year olds there, but they are the exceptions.

We have a three-bed room, 2 four-bed rooms, 3 two-bed rooms, and one private room. Each room is equipped with piped-in oxygen and suction. All of the two-bed rooms can be used as isolation units.

Visiting hours are the same as for adults, with no particular limit on numbers (some of them have friends by the score), and they seem to enjoy being able to see their younger brothers and sisters (banned in pediatrics). Stretchable visiting hours are from 2 to 4 and 7 to 8:30 p.m.

The hospital's selective menu is provided with at least two meat entrees and double portions if requested. Even hamburgers and French fries are sometimes available. We serve milk shakes, juices, carbonated beverages, and other between-meal snacks, unless ruled out by the attending physician.

Except for isolation patients, these kids have a great deal of roaming freedom. Because they can visit in other rooms, on foot or wheel chair, they make greater effort to get on their feet faster.

There is little depression. I sometimes have to dodge when I walk out into the fifth floor corridor because of the mild wheel-chair "drag racing."

I have to admit that things are perhaps a little noisy up on the fifth floor. But in spite of the great multiplicity of radios, television and hi-fi, teens are pretty considerate of each other, especially when someone feels a little worse than usual right after surgery.

We thought we'd like to find out what the teen-agers themselves thought. We distributed questionnaires to several hundred teen-age hospital patients of our own and a considerable control group of the same age in other hospitals which had no teen-age departments. Our teen-age department patients were unanimous in their approval of a teen-age section. So were 85 per cent of the teen-agers in other hospitals who had had no such good fortune.

In cost to the hospital the teen-age department ranks with those of adult patients, unlike the more expensive pediatrics with its greater nursing needs.

We have paid particular attention to nursing staff. We knew we needed wise, flexible nurses, capable of good humor, common sense, and a better than average understanding of the peculiarities of this age group. We didn't want them too young, because they couldn't command the respect, or too old, because these were more set in their ways.

We have cards and games available, also a magazine and book shelf. Television sets are available on a rental basis, or the patients can bring their own portables. Almost everyone has his own radio. The department is full of flowers, gadgets, and stuffed animals most of the time, and the traffic from room to room is very heavy. We don't use the short hospital gowns as a rule. We use bright-colored pajamas. We have a telephone available to wheel-chair and ambulatory patients, and we are planning a recreation room.

In cooperation with the public school system, teachers come in for classes for the long-term patients. Our women's auxiliary has recently undertaken a program of recreational work, and it is astounding to see the interest these young people show in weaving and other crafts.

We do not admit patients to the teen-age department who have been hurt while involved in any lawbreaking. The entirely innocent victims are a different matter, however.

If the patients won't give up smoking, we put them elsewhere, but we find they're so eager to be with their own age group this is no sacrifice.

Disadvantages? I'm sorry, they are so few and so minor, we no longer even consider them. Our teen-age department is here to stay. ■

46-2

Employe Poll Tells Hospital How It Stands

Employe attitude surveys conducted by this hospital have proved useful in guiding management in establishing personnel policies, and also have brought the comforting knowledge that its employe "climate" is a warm one

R. F. Hosford, H. W. Maysent, and R. L. Harrington

IT CAME as no great surprise to the administration of the 400 bed Lankenau Hospital, Philadelphia, that an employe opinion survey proved that the majority of our employes like their jobs, their supervisors, and — most of all — one another. Such comments as "I like my job;" "This is the best job I have had in my lifetime," and "The hospital has a very good employe-management relationship" shine like a light in the current darkness of adverse hospital publicity emanating from union organizations in many large cities.

Not all replies were favorable, inevitably. There were, for example, complaints about the prices charged to hospital employes by the pharmacy; some employes contended that the questions in the survey were loaded on the side of management. One employe stated succinctly: "Cafeteria food terrible." However, another found the cafeteria food good — but considered the prices too high. Again, there were some negative opinions expressed about pay, communications between departments, and the attitudes of supervisors, but, in general, the survey gave heartening evidence that our employe "climate" is warm.

This survey of our employes' attitudes toward the hospital is the second we have conducted, and we plan to make it an annual project. The study was made in a series of 26 meetings over a three-day period. Meetings were held at various times to allow for different work schedules. Out of 636 employes eligible to participate (we deliberately omitted department heads and first-line supervisors), 445 participated. This represents a 68 per cent return and therefore a statistically true picture of what our employes are thinking. The failure to obtain a 100 per cent participation was attributed to some employes being on vacation, sick leave, days off, and other circumstances beyond our control. It is anticipated that next year our percentage of participation will be improved as we plan to conduct it at a time other than the peak vacation period.

The current percentage of participation is better than we experienced with the first employe survey conducted in July 1957. Two hundred and eighty-three out of 570 eligible employes participated in that questionnaire. Because of the length of the questionnaire (54 questions) and the fact that few of our employes had ever been exposed to an attitude survey, the procedure followed was different in that the questionnaire was mailed to the employe's home with a request that the completed form be returned in a postage-free envelope provided for that purpose. Although the 49 per cent participation was below the statistically desirable level, it was felt the returns did indicate the feelings and opinions of the majority of employes. Anonymity was assured in all instances.

As has been mentioned, the second questionnaire was primarily designed to determine systematically the prevailing employe "climate." Thus, all but three of the 19 questions used in the questionnaire dealt with the employe's attitude or feelings concerning certain aspects of his relationship with the hospital. The three questions not concerned with attitudes covered the employe's knowledge of the hospital merit rating program, knowledge of the results of his last merit rating, and the employe's length of service.

To facilitate the analysis of the replies according to the general areas toward which negative and positive feelings of employes were directed, all persons who participated in the survey were divided as follows:

1. Professional: nurses, technicians, dietitians, pharmacists, physical therapists.

2. Nonprofessional: housekeeping, laundry, dietary, maintenance and engineering.

3. Clerical: secretaries, typists, clerks, accounting personnel, switchboard operators.

The specific questions listed in the questionnaire were developed to provide information on the following eight factors:

1. Job Satisfaction.

2. Intragroup Relationship: How the employe feels about the teamwork of his fellow department employes and how he identifies himself as a member of the team.

(*Text Cont. on Page* 119)

Mr. Hosford is director of Lankenau Hospital, Philadelphia; Mr. Maysent is associate director, and Mr. Harrington is administrative associate.

Copies of the questionnaire described in this article may be obtained by writing to the hospital.

Employe Appraisal Form Used at Lankenau Hospital

EMPLOYE APPRAISAL

NAME _____ **DEPARTMENT** _____

JOB DESCRIPTION _____ **DATE** _____

This Form is designed to help you appraise accurately the value of employees to the hospital. You are asked to rate the employee on each of the several traits or qualities listed below. After each trait there is a line representing various degrees of the trait. **The descriptive phrases beneath the line** indicate the amounts or degrees of the trait represented by points along the line. They are guide-posts. You rate the employee by checking at any place along the line that represents your judgment of him.

Quality of Work Ability to Produce Work Free from Error; Ability to Detect Errors; Accuracy; Neatness and Orderliness of Work.	Doubtful that Quality is Satisfactory	While not Unsatisfactory, Quality is not Quite up to Standard	Quality is Quite Satisfactory	Quality of Work is Superior to that of General run of Employees	Exceptionally High Quality
Volume of Work The Speed or Rapidity with which work is accomplished; The quantity of work produced in a given time.	Unusually High Output	Turns Out More Work Than General Run of Comparable Employee	Average Satisfactory Output.	Inclined to be Slow	Insufficient Output
Capacity to Develop Ability to grasp a situation and draw correct conclusions; Ability to profit by experience; Common sense.	Future Growth Doubtful	Moderate Development Ahead	Shows Promise	Very Promising Promotional Material	Great Future Growth Probable, Should go Far
Initiative Resourcefulness; Success in doing things in new and better ways and in adapting improved methods to his own work; constructive thinking.	Seeks and sets for himself additional tasks; Highly Ingenious	Resourceful; Alert to opportunities for improvement of work	Does regular work without waiting for directions	Sometimes needs to be prodded	A routine worker; usually waits to be told
Work Attitude Industry; Diligence; Attentiveness; Energy and Application to Duties; The Degree to which the employee really concentrates on the work at hand.	Extraordinarily Enthusiastic about his work	Shows eager interest in work	Shows normal interest; All that is ordinarily expected	Sometimes appears indifferent	Goes about work half-heartedly
Attitude Toward Others Ability to win confidence and respect through his personality; Courtesy and tact; Control of emotions; Poise; Cooperativeness.	Inclined to be quarrelsome, surly, touchy or uncooperative; Upsets morale	Sometimes difficult to work with	Normally tactful and obliging; Self-controlled	Always congenial and cooperative	An unusual and strong force for Hospital morale
Knowledge Of Work Present knowledge of job and of work related to it; Specialized knowledge in his particular field.	Has remarkable mastery of all phases of his work	Thorough knowledge of practically all phases of his work	Adequate knowledge; knows job sufficiently well	Insufficient knowledge of some phases of job	Has not gained adequate comprehension of his work

RATED BY: _____ **TOTAL** _____

REVIEWED BY: _____ **DATE** _____ **FINAL RATING** _____

3. **Job Security:** How secure the employe feels in his present position and his reaction to the reason some employes may have been discharged.

4. **Salaries:** How the employe feels about the pay in terms of the job he is doing.

5. **Supervisor-Employe Relations:** How the employe feels about his supervisor as a leader and as a person in terms of ability, fairness, friendliness and similar traits.

6. **Knowledge of Job Performance:** How the employes react to comments as to their improvement, deficiencies or progress in their work.

7. **Hospital Personnel Policies:** How the employe feels about the over-all hospital personnel policies.

8. **Merit Rating Program:** How much employes know about operation of the merit rating program and each employe's understanding of his last merit rating.

Returns on the questionnaire were summarized for each of the three categories of personnel. A master summary or composite was then constructed for all three groups. To enable us to interpret the data properly, the correlation existing between the employe's length of service and his reply was included. Favorable attitudes were expressed by all groups of employes. These attitudes became increasingly favorable as the employe's tenure increased. This observation tended to support our long standing contention that a personnel program designed to reduce turnover through adequate pay scales, good working conditions, and fringe benefits is sound.

The composite replies showed the most positive feelings were directed toward job security. An impressive 70 per cent felt Lankenau was "among the best" hospitals on the matter of steady employment, while 22 per cent marked "about the same as most hospitals," and only 2 per cent checked "one of the worst hospitals." Another 6 per cent did not reply.

The answers to questions relating to supervisors revealed favorable majorities in nearly all categories: 87 per cent felt their supervisors demonstrated "average" to "above average" ability; 88 per cent indicated their supervisors were "usually" to "always" fair and reasonable in dealing with employes, and 84 per cent felt their supervisors "usually" or "always" corrected them in a helpful manner when they did something wrong.

Bosses Know Their Jobs

In a five-part question also dealing with supervisors, 88 per cent replied that their bosses were "average" to "excellent" in their knowledge of their jobs; 77 per cent rated them "average" to "excellent" in their willingness to delegate authority.

Our need for improving communications was indicated by the relatively low 65 per cent reply on the employes' feelings concerning their supervisor as "average" to "excellent" in keeping them informed as to what was going on in the hospital. The need for better communications was again borne out in replies to the question of how well our employes understood the hospital merit rating program.

Only 31 per cent of the employes indicated that they "completely" understood the merit rating system, while 62 per cent felt that they understood it "partially" or "not at all." There were no replies in 7 per cent of the questionnaires.

On the question of pay, the response was only lukewarm, which was not wholly unexpected in an era when the cost of living index continues to shrink the purchasing power of the dollar. In consideration of their duties and responsibilities, 70 per cent rated their pay from "very good" to "just satisfactory"; 18 per cent considered it "too low," and 2 per cent did not reply.

We have had a policy at Lankenau of raising salary brackets with reasonable frequency for the past several years. Our minimum starting wage in the lowest bracket is at the national level of $1 per hour. While this figure varies considerably geographically, it is above the average for hospitals in our area.

In addition to salary changes, we have managed to provide several fringe benefits. These include: a noncontributory $1000 life insurance policy for all full-time employes; a liberal pension plan to which the hospital contributes 75 per cent of the cost (in addition to social security); the 40 hour work week; courtesy allowances on hospital bills for employes and their dependents; substantial discounts on meal tickets; recreational activities; sick leave allowances; employe health services, and the usual seven paid holidays and vacation allowances. Also, an effective grievance machinery has been in existence to ensure fair consideration when employes do have a grievance.

It seems to us that the success or failure of an attitude survey is based upon two important aspects: First, the employes must be informed of the results — all of the results and not just those favorable to management; and second, they must be advised as to the action taken or contemplated by management because of the study.

In line with this belief, the results were published in a special edition of our monthly employe newspaper, the *Orbit*, shortly after the survey was completed. This was followed by a release to the local newspapers.

It was possible for the administration to act on many of the constructive suggestions offered by the employes and these actions were also reported in the *Orbit*.

Attitude surveys can be a valuable tool in policy decision, and what could be more rewarding to management than receiving a comment such as this one from one of our nonprofessional workers: "I think, in general, this is a pretty good place to work. It will undoubtedly get better because you are seeking to find out what is wrong and in my opinion that is a major step. Thanks." ■

Employe appraisal form at left is basis for merit rating system used at Lankenau Hospital. Form is filled out by supervisors at regular intervals and should be followed by a discussion of the rating between supervisor and employe before it becomes a permanent part of the employe personnel record. Examination of comments from the employes' attitude survey, however, showed that less than one-third of all employes really comprehended how the merit rating system worked, indicating to management that some of the hospital's current personnel policies had not been made clear.

ABOUT PEOPLE

Administrators

Dr. John R. Heller, director of the National Cancer Institute, has been appointed president of Memorial Sloan-Kettering Cancer Center, New York. Dr. Heller received his M.D. from Emory University and was associated with the Georgia Department of Public Health. He joined the U.S. Public Health Service as a clinical investigator at a venereal disease center in Hot Springs, Ark., and became chief of the service's venereal disease division before joining the National Cancer Institute, which is also affiliated with the U.S. Public Health Service.

Milton W. Hamilt, former assistant director of Sinai Hospital, Baltimore, has been appointed assistant director of Mount Sinai Hospital, Chicago. Mr. Hamilt is a graduate of the Yale University course in hospital administration and served his administrative residency at Grace-New Haven Hospital, New Haven, Conn., where he remained for two years as administrative assistant. Before his appointment in Baltimore in 1956, Mr. Hamilt was administrator of Yale Psychiatric Institute for one year. He has been secretary of the Junior Administrators of Baltimore since 1957 and chairman of a special committee of the Hospital Council of Maryland in 1959. Mr. Hamilt is a member of the Connecticut Hospital Association, American College of Hospital Administrators, American Public Health Association, and the Royal Society of Health in England.


M. W. Hamilt

Arthur G. Hennings has been appointed administrator of St. Margaret Memorial Hospital, Pittsburgh. Mr. Hennings was a staff consultant for James A. Hamilton Associates, hospital consultants, in Minneapolis. He has been director of hospitals at the University of Texas Medical Branch, Galveston, and assistant professor of hospital administration at the University of Minnesota. Mr. Hennings also has served on the administrative staff of Butterworth Hospital, Grand Rapids, Mich., and Northwestern Hospital, Minneapolis. He is a fellow of the American College of Hospital Administrators.

Christian M. Christiansen has been named administrator of Children's Hospital, Baltimore, succeeding the late **Carrol D. Hill,** whose death was reported in the May issue of The MODERN HOSPITAL. Mr. Christiansen was formerly administrator of Union Memorial Hospital, and controller and administrative assistant at Johns Hopkins Hospital, Baltimore.

John M. Duggan has been appointed administrator of Astoria General Hospital, Astoria, Long Island, N.Y. Mr. Duggan, formerly assistant administrator and assistant director of planning of Misericordia Hospital, Bronx, N.Y., previously was administrative assistant at Jewish Hospital, Brooklyn, N.Y.

Eva Weiss has been promoted to the centerwide staff of Albert Einstein Medical Center, Philadelphia, from her position of first assistant administrator of the southern division of the center. Mrs. Weiss was formerly assistant administrator of Northern Liberties Hospital, Philadelphia, which later became the eastern division of Einstein Center. At the same time, it was announced that at the southern division, **Bernard M. Weinstein** has been appointed first assistant administrator. Mr. Weinstein served his administrative residency at Beth Israel Hospital, Boston, and came to the southern division as an administrative assistant and later was promoted to second assistant administrator. **Richard M. Vogel** has been named as the new second assistant administrator.

Sister Juliana Kelly has been appointed administrator of St. Vincent's Hospital, St. Louis, Mo., succeeding **Sister Josephine Aitchison,** who is to be administrator of St. Mary's Hospital, Milwaukee. Sister Juliana is former supervisor of the psychiatric division at Charity Hospital, New Orleans; her academic training includes her R.N. from Charity Hospital School of Nursing, a B.S. in nursing education from Louisiana State University, and an M.S. in psychiatric nursing from the Catholic University of America.

Carl Nusbaum has been appointed executive director of Gottlieb Memorial Hospital, now under construction in a Chicago suburb. Mr. Nusbaum is a former executive director of Rest Haven Rehabilitation Hospital, Chicago, and served as assistant director of Michael Reese and Mount Sinai hospitals, Chicago. He is chairman of the committee on the Care of the Aging of the Illinois Hospital Association.


C. Nusbaum

Dr. Charles P. Henke, manager of Veterans Administration Hospital, Pittsburgh, has been appointed director of domiciliaries for the V.A. in Washington, succeeding **Dr. M. H. Travers,** who is retiring from government service. Dr. Henke received his B.S. and his M.D. degrees from Northwestern University and is a diplomate of the American Board of Surgery. Dr. Henke was resident in surgery at Veterans Administration Hospital, Hines, Ill., and was formerly director of professional services at Fargo, N.D., and Wood, Wis., V.A. hospitals.

Robert A. Tittle has been appointed administrator of Humphreys County Memorial Hospital, Belzoni, Miss., succeeding **Aileen Childress, R.N.** Mr. Tittle was business manager of South Mississippi Charity Hospital, Laurel, and received his master's degree in hospital administration from Northwestern University.

Margaret Beede has been appointed administrative assistant at Herrick Memorial Hospital, Berkeley, Calif. Miss Beede received her master of science degree in hospital administration from Columbia University School of Public Health and served her administrative residency at Herrick. Her previous positions include work in the personnel office of Philadelphia's city health department and as personnel director of Presbyterian Hospital, Denver.

(*Continued on Page* 194)



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Manual Shows How Much a Pharmacist Can Do

The procedure manual of the pharmacy in a 100 bed hospital presented here indicates how many useful functions the pharmacist can perform that save time for the staff and money for the institution

Margaret Gretz

ADMINISTRATORS of small hospitals frequently ask themselves, "Will my hospital have enough work for a pharmacist?" The answer is definitely "yes" if the pharmacy is run not merely as a drug dispensing station, but as the center from which medications are issued with care and understanding of the particular problems of the hospital.

The procedural manual of the 100 bed Margaret R. Pardee Memorial Hospital, Hendersonville, N.C., presented here shows that it is a simple matter to figure the hours gained by the nursing department, business office, and the administrator through the activities of the pharmacist. It also suggests the savings incurred in stock control, knowledge of drugs, and limitation of costly duplication through a formulary service.

The administrator who finds it infeasible to employ a pharmacist for less than 40 to 44 hours a week should consider other areas where the pharmacist could fit in easily. For example, control of purchases for central supply and operating suite, time and cost studies on new methods and materials in these two departments; supervision of oxygen therapy; advice and assistance in buying of disinfecting and cleaning solutions for the housekeeping department, and advice on the selection of supplementary food items for the dietary department can be furnished by the pharmacist.

Teaching of pharmacology may be considered a luxury by the hospital which does not have a school of nursing connected with it, yet many registered nurses want information on the ever-increasing number of drugs. They are grateful to obtain such information at the source where it can be most easily and accurately given — the pharmacy. For instance, charts may be prepared by the pharmacist to explain difference of action and duration of the many types of insulin, and dosage and action of tranquilizers, heart medications, and other drugs. Such aid from the pharmacist will be gratefully accepted by the nurse who often finds herself bewildered by the increasing complexity of drugs.

Occasionally some form of research will be needed. At our hospital, for example, the pharmacy department collaborated with the pathology laboratory to test all sterilizing and disinfecting solutions then in use at the hospital for their effectiveness against Staphylococcus aureus. It was a time consuming but most rewarding and worth-while project.

Margaret Gretz is a registered pharmacist at Margaret R. Pardee Memorial Hospital, Hendersonville, N.C.

Pharmacy Procedures at Pardee Memorial Hospital

The pharmacy is under the supervision of a registered pharmacist who is on duty Monday through Saturday from 8 a.m. until 1 p.m. Any time that it is necessary to extend these hours because of a heavier than normal patient load or any emergency, this can be done at the discretion of the pharmacist. All medication orders, and requests for floor stock items, narcotics and alcohol are filled during these regular hours. In addition, the pharmacist is, of course, on call at all times for any emergency that may arise.

All shelves, cabinets and drawers in the pharmacy are marked with a letter and, if subsectioning of the storage unit requires it, with a number. Drugs and medications kept in stock at the pharmacy are listed in alphabetical order in an index which indicates their location by letter and number. If any index card shows more than one location, it means that the item in question is prepackaged for ease and speed in dispensing.

Medication Orders: They are made out for the individual patient and must indicate the patient's name, room number, the date, the name of the medication, the dose, frequency and route of administration, and the prescribing physician's name. They



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are signed by the nurse who orders the medication from the pharmacy. Medications are dispensed by the pharmacy in such a way that any further handling of them before administration is unnecessary. Thus, dividing or crushing of tablets, diluting of injections, or of stock solutions are done by the pharmacist. The amount of medication dispensed for any one patient is usually a quantity sufficient to last for four or five days; three days for antibiotics. Exceptions to this are the so-called Rx items. They are medications which once they are dispensed cannot be taken back by the pharmacy. They are marked with an Rx as they are dispensed. These are all drugs which are not ordinarily kept in stock at the hospital but are ordered from a drugstore for one particular patient; items which become unstable when they have been opened; all ointments other than those kept on dressing carts; all sprays, drops or ointments designed for use in eye, ear, nose or throat; all medications which are compounded by the pharmacist for use by just one particular patient.

All medications dispensed to one patient are returned to the pharmacy when that patient leaves the hospital. By agreement with the local drugstores, all prescriptions written for use outside of the hospital after a patient is discharged are to be filled in a drugstore of his choice and not in the hospital pharmacy. Exceptions to this are items which are unobtainable outside of the hospital (such as certain intravenous solutions) and items already charged as Rx items during the patient's stay at the hospital. These latter medications must be brought to the pharmacy for labeling with the physician's directions before the patient takes them home.

Floor Stock Items: All such items as are used regularly and frequently are kept on the floors as floor stock items. Empty or nearly empty containers are brought to the pharmacy for refill together with the floor stock request slip. A list of floor stock items is supplied to each floor which indicates the maximum quantity that will be supplied at any one time. Any addition to this list will be made at any time the head nurse finds it necessary to request it. To help with the planning and ordering of supplies, it is desirable that floor stock orders be brought to the pharmacy before 10 a.m.

Generic Names: In agreement with a ruling by the council on pharmacy and therapeutics of this hospital, all drugs shall be dispensed by generic name.

Metric System: In order to familiarize physicians and nurses with the use of the metric system of weights and measures, all drugs ordered in the apothecary system will show on their label the metric weight or measure and the apothecary equivalent of it. Tables of the equivalent weights of the two systems are posted on all nursing stations and may also be found in the formulary.

Formulary: The formulary lists all drugs that are approved by the council on pharmacy and therapeutics for use in this hospital. The contents are classified as to pharmacological use and indexed accordingly. An additional alphabetical index listing generic and most commonly called-for brand names is to be found in front of the book. Copies of it are posted on all nursing stations and have been given to each member of the medical staff.

The formulary is reviewed twice yearly by the council on pharmacy and therapeutics and additions or deletions are made at that time.

Provides Safeguards

Narcotics: All narcotic medications that are routinely given are requested by handing in the completed narcotic proof sheet with the empty container. The narcotic proof sheet is self-explanatory, but it should be mentioned that the nurse who administers the narcotic must sign her name in full and not in initials only. A registered nurse only can call for the narcotic at the pharmacy and must sign a receipt upon delivery. Narcotics are given out only during pharmacy hours by the pharmacist, or in an emergency the pharmacist is called. Narcotics which are not routinely given and are not recorded on the proof sheets must be ordered by the physician the same way as he would order them from a drugstore. A perpetual narcotic inventory is kept by the pharmacist.

Alcohol: Solutions containing alcohol, such as surgical solution or back rub, are requested on a special form supplied by the pharmacy. All requests that are filled are listed in the monthly alcohol inventory.

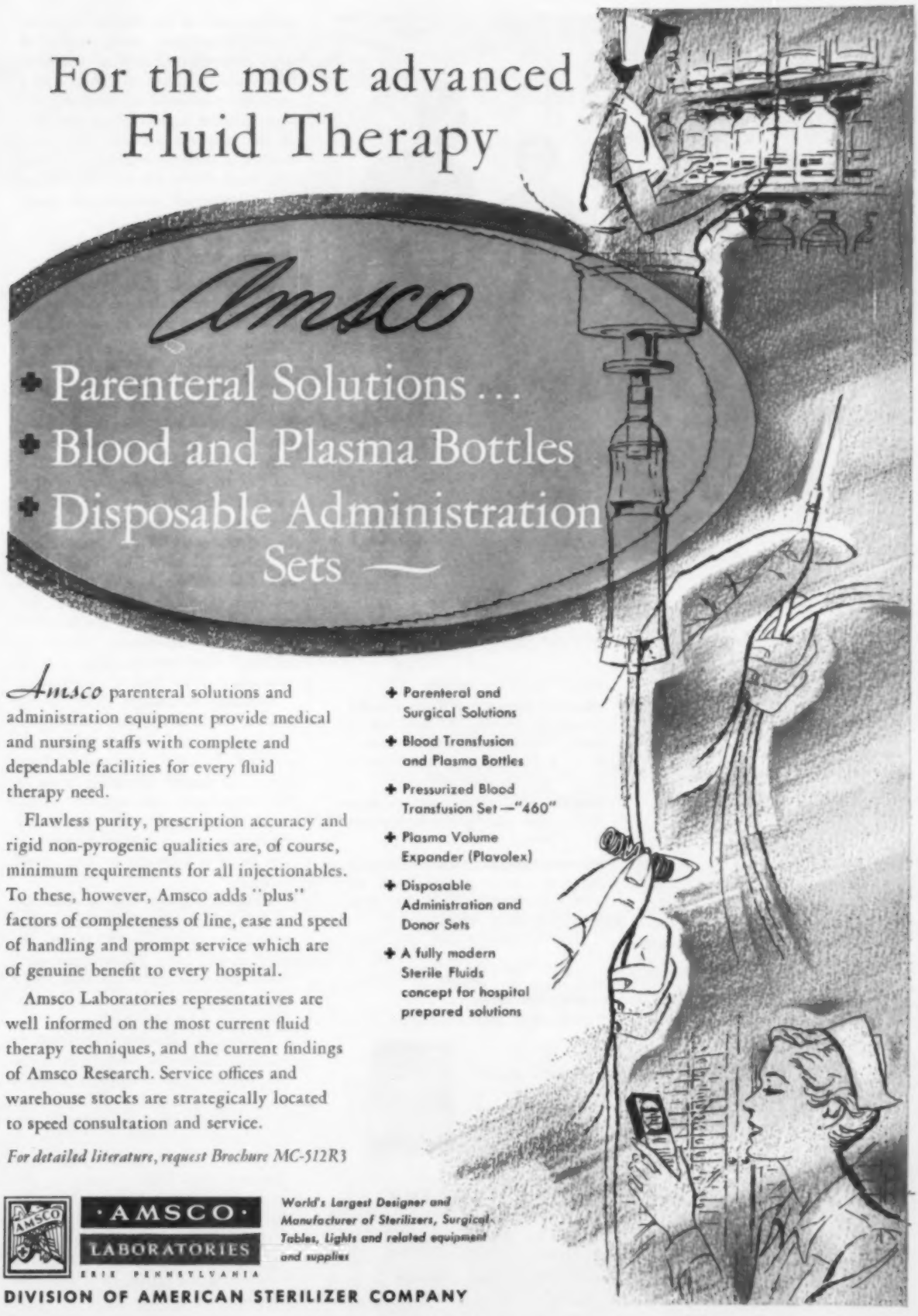
Investigational Drugs: These are handled according to the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals Approved by Board of Trustees of the American Hospital Association — September 29, 1957." Thus, the pharmacy committee has ruled that "if a physician wishes to use a drug which is still on an investigative status, that he fully inform the pharmacist of the nature of the drug, provide the necessary literature available, and post the floor nursing personnel as to its nature and possible untoward reaction before such drug is used. All investigational drugs will be issued to the floor from the pharmacy."

Drugs Brought Along Upon Admission: In agreement with the pharmacy committee no drug shall be brought in by a patient for relabeling by the pharmacist for use in the hospital. No exceptions will be made to this policy except in the case of a very expensive medication which has a short expiration date. In such instance, the physician shall take the medication personally to the pharmacy for relabeling.

Emergency Cabinet: Such medications as are necessitated by change in physician's orders during the afternoon or by new admissions coming in after the pharmacy is closed are obtained by the supervisor of the nursing staff who carries the key to the pharmacy. For this purpose all medications other than injectables are prepackaged in small units and stored in a separate section. They are completely labeled except for patient's name and room number. A code-numbered detachable gummed sticker is attached to the cap of the vial or bottle which, at the time of removal from the shelf, is detached from the container and affixed to the corresponding medication order. The same code number must be marked on the original bottle from which the pharmacist has dispensed the medication into the emergency unit.

Prepackaging: The foregoing refers to drugs that are called for only infrequently. Those which are ordered more frequently are prepackaged in greater quantities. A prepackaging record is kept of these on individual index cards listing all pertinent infor-

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mation, such as lot number of manufacturer's container, date, number of units prepackaged, size of container used, label and so on. These index cards are numbered consecutively, the same number appearing on the label of the prepackaged unit. The same method is used for relabeling of original bottles of pediatric suspensions and other small size original manufacturer's bottles.

Manufacturing Records Kept

Manufacturing of several U. S. P. and N. F. preparations is done at the pharmacy, as well as of several solutions used in central supply. A manufacturing record, listing date and amount manufactured, is kept.

Charging of Medications: All medications are charged by the pharmacist after they have been administered. For this purpose, a carbon copy of the medication chart of each patient, listing all drugs administered from midnight to midnight, is brought to the pharmacy in the morning and the prices are added by the pharmacist. The completed charges go to the business office. An exception to this procedure is made with the so-called Rx drugs as mentioned, which are charged on a special ticket by the pharmacy at the time of dispensing.

Ordering of Drugs: Drugs to be kept in stock at the pharmacy, operating room, and central supply are ordered by the pharmacist from either the nearest wholesale house or the respective manufacturer's warehouse. Only nationally recognized companies are considered. A purchasing index is kept up to date at all times.

Hospital displays may be held by manufacturers' representatives in the front lobby of the hospital. A date for such display must be arranged with the pharmacist ahead of time. Only hospital-approved drugs may be displayed.

Books: The pharmacy bookshelf is available to anyone seeking information pertaining to drugs and contains up-to-date literature on pharmacology, availability, and prices of any drug item.

Poison Control Center: The pharmacist is responsible for keeping the antidote cabinet and the literature of the poison control center up to date and shall be available to give information relative to poisons and their antidotes if the physician on call cannot be located. ■



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Pharmacist Makes a Good Purchasing Agent

Combining the duties of purchasing agent with those of pharmacist makes it possible for the small hospital to provide full-time pharmacy service

Henry Amicarella

PURCHASING is a logical extension of the pharmacist's duties – especially in the small hospital that does not require the full-time services of both department heads. Such a combination solves the problem of providing professional pharmacy service, which every hospital needs, at a price most hospitals can pay.

That, at least, is the view at Longmont Community Hospital, Longmont, Colo., where this combination has proved successful.

Basically, a pharmacist is needed to provide good, safe and efficient pharmaceutical services to the patient. He is also needed to develop and maintain standards, to purchase drug supplies properly, to do needed manufacturing, to organize and supervise storage properly, and to dispense efficiently all drugs used in patient care.

Other services often performed by the pharmacist include control of narcotic drugs and alcohol, providing information and service to the medical staff and other personnel, establishing a control center for poisons and antidotes, and teaching on a formal or informal basis.

Services to various departments can be provided by the hospital pharmacy. For example, in the dietary department, the pharmacist can suggest certain dietary supplements; in the housekeeping department, the pharmacist can suggest certain detergents, antiseptics and disinfectants for use in cleaning and scrubbing; in the maintenance department, the pharmacist can suggest certain paint removers and the like. He can help the laundry by suggesting stain removers and cleaners.

He is in the best position to advise the medical staff and administration on developments in drugs like penicillin, cortisone, and prednesone, vaccines and tranquilizers.

The pharmacist can also assist in carrying out surveys and studies to find ways to improve procedures and technics. For example, our pharmacist has been particularly helpful in various studies and suggestions in the use of disposable items such as gloves, needles, syringes and oxygen masks. As the result of these studies and recommendations, our hospital is using some of these disposable items.

Inventory control in purchasing can be best handled by the pharmacist. Careful and economical buying protects the hospital and its budget. The pharmacist has given us considerable help on this one problem alone, by, for example, recommending that lotions be bought in larger quantities and rebottled in smaller containers.

Sound pharmacy operation can help the hospital financially by providing a source of revenue that would not otherwise be available. Small hospitals have a considerable financial and legal stake in maintaining efficient controls which a qualified pharmacist is equipped to handle.

Financial controls such as drug charges, requisitioning and dispensing of drugs, and proper records and bookkeeping are, in our experience, best carried out by the pharmacist. He is also in the best position to systematize the purchase of drug supplies and to institute inventory controls.

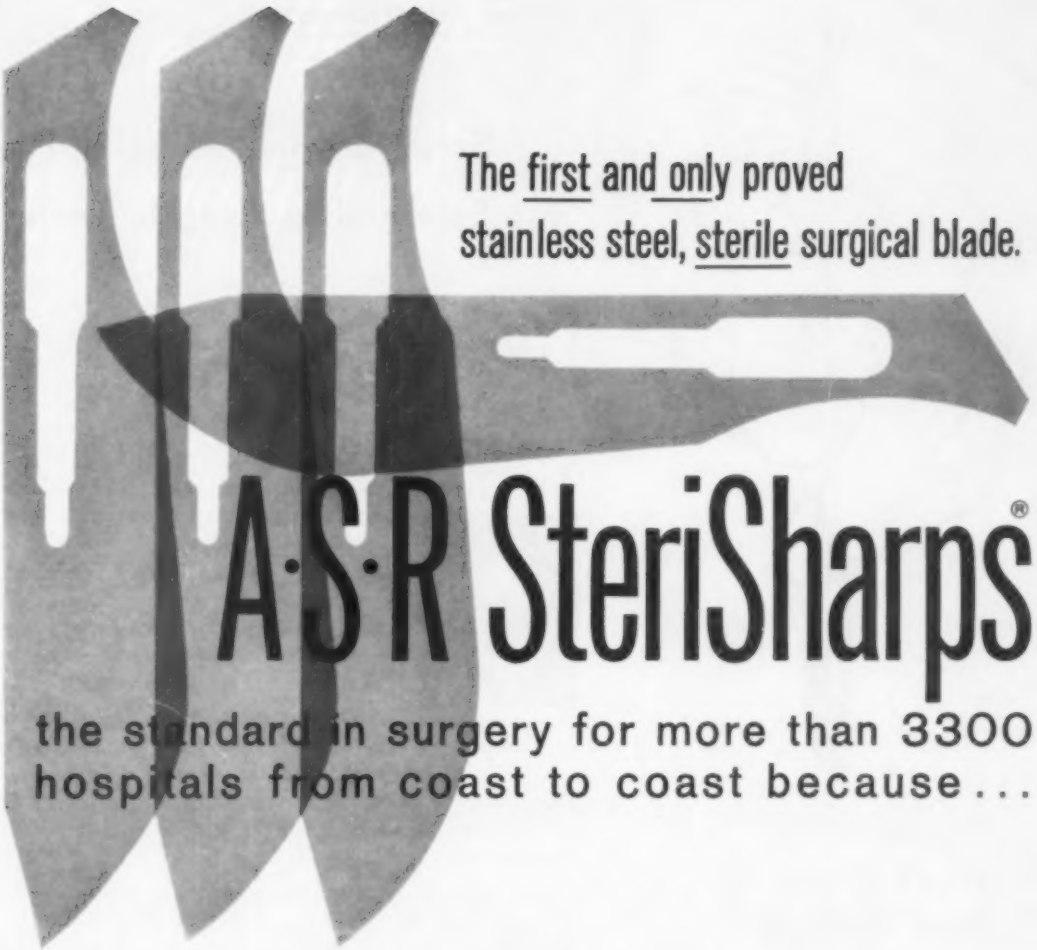
When a pharmacist is available, an inspection program can be carried on throughout the hospital on a systematic and regular basis. Drug cabinets should be inspected by the pharmacist for drugs that are outdated or deteriorated or improperly labeled. He can inspect biologicals that may be out of date. A check by the pharmacist ensures better drug conditions and safer use of drugs.

The purchasing function is inherent in the work of the pharmacist in seeing the detail man or salesman, in selecting between various brands, and in providing for drug information, samples and materials. This is for the protection of the hospital, patient, doctor, the pharmaceutical committee, and other personnel. ■

[1] Adapted from a paper presented to a seminar for hospital pharmacists and hospital administrators, sponsored by the University of Colorado College of Pharmacy and the Colorado Society of Hospital Pharmacists, Boulder, 1959.



Henry Amicarella is administrator of Longmont Community Hospital, Longmont, Colo. Previously, he was administrator of Longmont Hospital and Clinic there, and of Good Samaritan Hospital, Sandusky, Ohio. Mr. Amicarella received bachelor's and master's degrees from Colorado State College of Education and a master's degree in hospital administration from Northwestern University. He is a member of the American College of Hospital Administrators.



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Scrub Brushes and Nail Files Essential to Aseptic Technic

By Frances Ginsberg, R.N.

SOMETIMES I have been accused of "lint picking" when it comes to asepsis. Lint picking, in case you are not familiar with the term, means taking issue on certain things which ordinarily neither get, nor seem to deserve, attention in the face of more important things. Bacteria are, of course, much smaller than lint and, knowing the trouble they can cause in the hospital and especially the operating room, no bit of "lint" is too small for me.



Frances Ginsberg

The analogy seems to apply to such things as scrub brushes and nail files in the scrub room. Although these areas are only "surgically clean," there is no excuse for inviting trouble by using such things as a common container for brushes, ineffective brushes, and orangewood sticks to clean fingernails and cuticles.

The obsoleteness and absurdity of these practices are obvious when we note that there are several types of modern brush dispensers. These deliver one sterile brush by a finger, elbow or foot controlled lever and do away with everyone reaching into the same container for brushes with both clean and unclean hands. One such unit for every two scrub sinks has proved effective. The purchase of such units should also include one extra magazine for each unit, so that while one unit is being washed and sterilized in its magazine, brushes will still be available from the other.

It is my opinion that the best type of brush has a plastic handle and nylon bristles. Such brushes can withstand repeated sterilization with minimal wear.

Orangewood sticks should have gone out with the invention of the stainless steel nail file, yet they are still in wide use. Such stainless steel nail files (and I use the plural because there should never be a community nail file) have proved more effective and can withstand repeated sterilization. Despite common practice of forgetting this, *they should be sterilized.*

Ideally, for the best possible practice, I would recommend the use of the unit in which the nail file is included with the brush. Once they have been used, they can be sterilized and ready for reuse in a condition that will assure proper asepsis.

This is another example of how a small investment can pay big dividends in terms of patient safety. In this case, a little lint picking is a good thing. ■

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.

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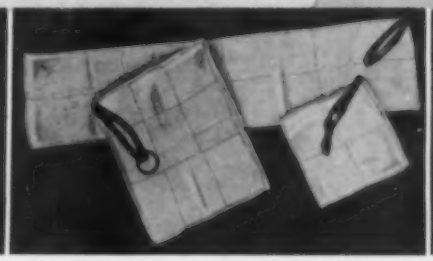
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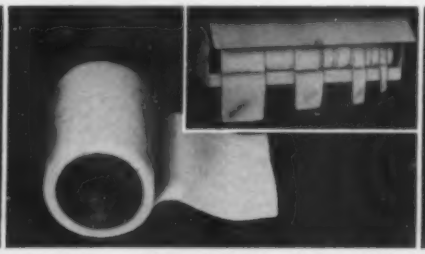
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Lay Technicians Could Assume Many More Nursing Functions

By Robert S. Myers, M.D.

WAR brings many innovations; some good, some bad. A good one from World War II was the demonstration that lay technicians could replace graduate nurses in many patient-care areas in military hospitals, particularly in the operating room.



Dr. Robert S. Myers

Since then, a number of civilian hospitals have trained and used lay people as surgical technicians and have found them entirely adequate in such areas as the operating room, central supply, delivery room, and accident room.* This, of course, should occasion no surprise; for years, student nurses in the primitive stages of their training have been used in these and other areas of hospitals with complete satisfaction. Moreover, in certain institutions, green interns have long functioned as excellent operating room instrument men. The specific duties entrusted to these student nurses and these interns have required little, if any, knowledge of anatomy, physiology, pathology and of the other scientific disciplines traditionally regarded as essential in the care of the patient. Required are sufficient intelligence and dexterity to master procedures that are entirely technical, the ability to follow directions, a pride in one's work, and direction and supervision of the work of these lay technicians by competent professional nurses.

But there are other areas in the hospital where the use of lay technicians should be considered. These have to do with the administration of intravenous therapy, of oral and parenteral medication, and of oxygen; with the maintenance and use of apparatus for suction and drainage, and many other aspects of patient care.

Such expansion of the use of the lay technician would do much to alleviate the shortage of nurses, which may be more apparent than real. For with the increase in modern medical knowledge, the professional nurse has had to assume many of the duties and responsibilities properly belonging to other groups. On the one hand, physicians have delegated to the nurse much of the care of patients, which formerly was done entirely by doctors; on the other hand, the nurse has had to absorb many foreign functions, such as responsibility for dietetics, the drug room, and housekeeping in many small hospitals without trained personnel in these areas.

This trinity of duties — medical, nursing, and administration — poses a thorny problem for the professional nurse. Her training, even at the highest level, does not qualify her to diagnose illness and to treat it independently; her education is too extensive to justify squandering her time on the mere technical details of patient care, and such ancillary duties as dietetics and housekeeping are beyond her field and wasteful of highly trained people.

The future may well demand that we have fewer and more highly educated nurses who will act purely as teachers and as supervisors of the work of technicians and others who care for the patient. After all, most nursing procedures are mechanical and technical and, as such, can be performed adequately by any ambitious, intelligent, dexterous youth eager for a career as a hospital technician.

*Ginsberg, Frances, R.N.: Aides Answer the Call for Help in Surgery. Mod. Hosp. 90:71 (February) 1958.



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Frances B. Floore

DIETITIANS sometimes become so concerned with the calorie, vitamin and mineral aspects of food that they lose sight of the psychological effect of food on the patient. He needs food to help him get well, but it must be food to intrigue his interest and appetite.

He might, for example, look with favor on a casserole of chicken and mushrooms in wine sauce, topped with almonds and toasted bread crumbs, while meat loaf, creamed potatoes, and peas would look too heavy and give him no incentive to eat.

We all cut our dietetic eyeteeth on the adage that "hot food should be served hot and cold food cold." We were also admonished to see that the napkins and tray cloths were white and clean, the silver well polished, the glasses and dishes free from chips and cracks, the food seasoned to taste, colorful to the eye, varied in flavor as well as texture, and served with gracious finesse. We have assiduously done all this and still hospital food often does not arouse the patient's interest or enhance his appetite.

Why? Dietitians are familiar with the problems of mass production, lack of imagination in planning, shortages of employes, inadequate budgets, and too little time. **It is also possible that they are inclined to feed the sick after the pattern of the well, forgetting that their caloric needs and appetite demands are much below par.** Most patients need to be cajoled into eating with delicate, tempting dishes that are rich in savor and aroma. This means changing the pattern of our menus away from the meat, potato and vegetable regimen we have been brought up on to one of somewhat lighter fare.

We might also borrow from the French, Latins and Greeks and include a small glass of wine in our hospital culinary cuisine. But it might take years to change our culture pattern in this respect, so we can settle on the use of wine as a flavoring agent. It is one of the most versatile ones in the world and wine adds a gourmet touch to most any dish from appetizers through desserts.

We are all acquainted with wine as a beverage but it is possible that some are not too cognizant of its value as a flavoring agent. It is not necessary to buy vintage or Chateau varieties. Domestic ones that come in gallon and half-gallon jugs are just as satisfactory for cooking and much easier on the budget.

All wines have three flavors: the natural, the simmered, and the cooked. If cooked too long or at too high temperatures there will be the burnt flavor, which will spoil any dish. As alcohol boils at a temperature of 172.2 F. all of the alcoholic content will have evaporated long before the boiling point of water has been reached. Those who object to the use of wine in cooking may not know that foods cooked with wine have only the flavor and aroma left without the alcoholic content. Vanilla and lemon extract, for example, are 80 and 100 per cent proof, while wine before cooking is only 8 to 12 per cent proof.

In cooking with wine the effect of a subtle flavor is desired and only small amounts are needed to attain this. Dry wines are preferable to sweet wines and those most often used in cooking are: sherry, sauterne, marsala, madeira, claret, port and burgundy.

There is a natural affinity between wine and soup. Soups have been given priority for the sick since ancient times. Pliny stated that the Romans boiled eggs, cheese, flour and water to make a nourishing soup. Virtually every country has a national soup with the climate varying its cultural pattern.

Soups give harmony to a meal and help to stimulate the appetite. They can be served as a clear bouillon, consomme, potage, puree, bisque, ragout, stew, vichyssoise, vegetable, chowder or cream soup.

Soups are enhanced by the addition of whipped cream, chives, leeks, watercress, parsley, paprika, curry powder, mushrooms or onions. For more sustaining fare, semolina or marrow dumplings, egg drops, barley, croutons, julienne of pancakes or vegetables, royal custard, profiteroles,

Miss Floore, a former hospital dietitian, is presently a dietitian at Carolina Inn, Chapel Hill, N.C.

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rice, vermicelli or potato can be added.

For a patient who wants "just a bowl of soup" it might be accompanied by a petite cream puff shell filled with chicken pate or miniature tart shells filled with ham salad or cream cheese and chives. Hot curried chicken or shrimp in tart shells (the size of a quarter) or eclair shells the size and shape of a peanut shell and filled with a pate of cream cheese and olives will add calories and luster to the soup course. All of these should be bite size.

Croutons flavored with butter and tomato, lemon or sherry are delicious. They may be cubed or cut in strips and rolled in parsley, chives or minced green onion tops. Cheese straws, cheese curls, and melba cheese add flavor to the soup. Children are especially fond of pop corn added to their soup.

If you have a patient with a lagging appetite, tempt it back to normal with a clear tomato soup garnished with sherried whipped cream. Or combine cream of chicken soup with cream of celery and flavor it with madeira. Split pea soup combined with sherry and tomato soup makes a good appetizer. Black bean soup thinned with chicken broth or consomme and a red wine is filling and flavorful.

On a hot, humid day when patients are uncomfortable and restless, a cup of jellied tomato madrilene surrounded by crushed ice and served with a wedge of lemon might cool them off and lift their morale. A chilled cream soup is also as refreshing on a hot day as a hot soup is invigorating on a cold day.

A cream soup may have the addition of any of the following: watercress, cucumbers, chives, chicken, turkey, veal, crabmeat, shrimp, lobster, mushrooms, potatoes or a puree of ripe olives, tomatoes, asparagus, spinach or peas straight from the garden. With a flavoring of wine and served cold, preferably in supreme glasses, they are all good.

Chilled cream soup with little ribbon sandwiches or petite hot rolls may take a perspiring, feverish patient's mind away from the weather. Use ingenuity in devising and creating subtle combinations of soups and your patient will be grateful for your consideration. One of my favorites is a lobster bisque seasoned with sherry and lemon and garnished with whipped cream tinted a pale green and topped with pistachio nuts. Served with quarter sized baking powder biscuits with a thin slice of turkey or ham between them, the soup course becomes a "one dish meal" that patients enjoy.

There are almost as many kinds of sauces as there are foods, but with the three basic ones it is possible to make countless others and they all begin with "first you make a roux." To this basic roux of butter and flour, or preferably butter and arrowroot, add seasonings and the designated liquid.

Bechamel is the mother sauce, or *sauce mere* and is what is known as white or cream sauce. Though the terminology may vary the three are all essentially the same sauce. The liquid used with the roux may be cream or milk or a combination of these and the flavoring should be a dry white wine. Bechamel is used with fowl, seafood, vegetables and veal. Chicken a la king is an example of the use of this sauce. Probably the classic example is eggs a la goldenrod.

A brown sauce is made by browning the flour before and after the butter is added. When the roux is a golden brown the meat stock or bouillon is added, and when thickened and smooth, red wine is added. Milk and cream are never used in making a brown sauce. It is used in combination with beef, mushrooms, venison and pork. Tenderloin tips with mushrooms in burgundy wine sauce is an example and may be served in an individual casserole with noodles or rice.

Veloute sauce is similar to bechamel but is made with the stock of fish, chicken, veal or beef. It may be made with all stock or with half stock and half milk or cream. Wine in the form of marsala, sauterne or sherry is added after the sauce has thickened. Veal gratin au marsala is an example of the use of veloute sauce.

All sauces must be cooked at low temperatures in double boilers, a bain marie, or a water bath because boiled milk, cream or wine changes the palatable flavor of the sauce to an unpalatable one. Sauces should be beaten with a French wire whip while being made to assure a creamy, velvety mixture. A lumpy or pasty sauce, one that tastes of raw flour, is not well seasoned, or is scorched is inexcusable. Never make sauces with flour and water. Butter, oleo margarine and oil heat to a higher temperature than water and serve to cook the flour, making a perfect roux. The wine should be added with the ingredients to be used with the sauce and all of them heated together at a low temperature.

Sauces can be made up in quantity and kept on hand a few days for emergency use. A few spoonfuls of melted butter poured on top will prevent the formation of skin. From these three basic sauces hundreds of others can be made that will vary the flavor and add zest to the menu.

A *beurre manie* or a roux can be made ahead and kept on hand to use as needed. If the sauce is too thin, add a little of this roux or *manie* to "tighten" it.

Some of the entrees that could be served in hospitals using these three basic sauces are: beef stroganoff, veal scaloppine, veal parmigiana, baked ham with claret sauce, lobster newburg, round steak bordelaise, and curried shrimp or chicken.

Eggs are another food that lend themselves to the addition of wine. A very sick person might relish a sherry eggnog or egg coddled with sherry. Eggs scrambled with sour cream and sauterne and served on

Fish à la Archestratus

There is a recipe that has come down through the ages from Archestratus, ancient Greek poet and gourmet. Writing in the Fourth Century, B.C., on how to cook Bonito fish, he stated:

"The best way to dress fish is to wrap it in fig leaves with a very little marjoram. No cheese, no nonsence! Just place it tenderly in the fig leaves and tie them up and put under hot ashes, bethinking thee wisely of the time when it is done and burn it not up."

The last four words should be emphasized; fish is too often overcooked and served dry and unappetizing. ■

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toast with a rasher of crisp bacon are good and so is a sherried omelet or welsh rabbit.

Fish is another food that is improved by the addition of wine as well as by butter, lemon, almonds or cocktail sauce. It is a truly gourmet food that is too often left off the hospital menu.

Chicken is an extremely versatile food and there are as many ways to serve it as there are days in the year. Chicken mornay baked in an avocado shell au gratin is good and so is crabmeat newburg in a green coconut shell, baked with toasted crumbs and almonds. The problem is to find a green coconut outside of Florida or California, and then find someone with a machete to lop off the top.

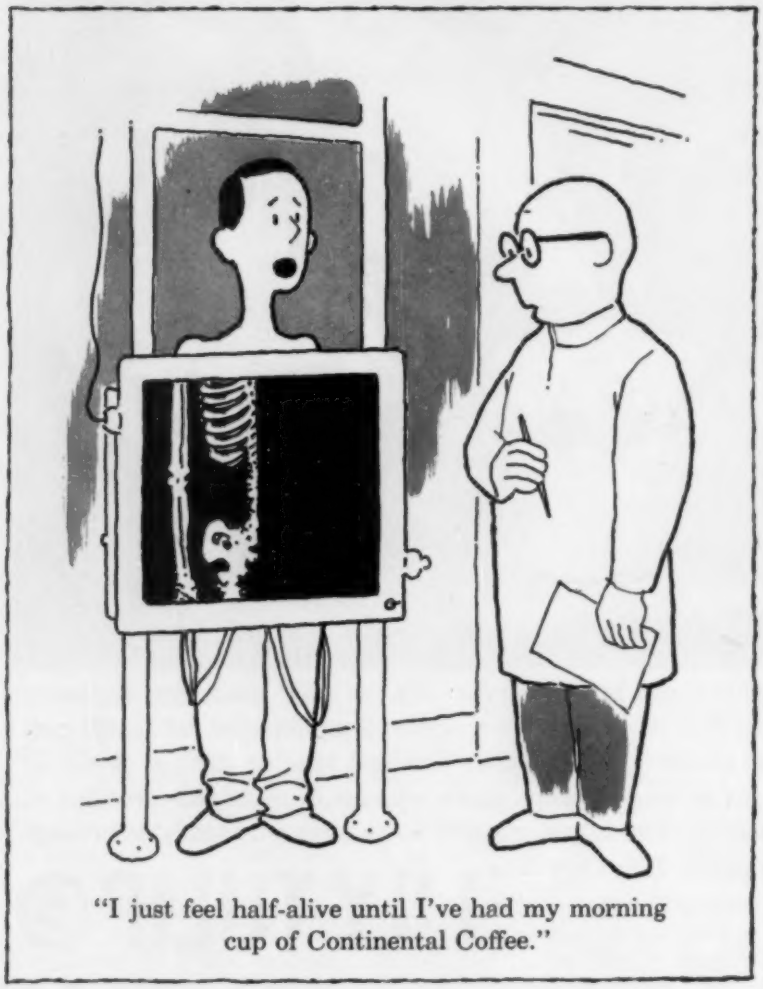
We could vary our vocabulary of culinary terms to include: chicken cacciatoire, carioca, tetrazzini, teryaki, Lady Pompadour, Provencal, arroz con pollo, sans souci, Maryland, Florentine, vermouth and hundreds of others.

Veal can be prepared in many ways that patients would find interesting. Stuffed veal birds with pecan dressing with a wine and cream gravy, or veal with water chestnuts and bamboo shoots served with curried rice or rice pilaf, makes fine eating.

Most desserts are improved by the addition of wine. The basic ingredients of the French desserts are simple ones, but from these can be made various attractive and colorful dishes. These five ingredients are eggs, milk, cream, sugar and butter. With wine to flavor they can be made into meringues, pot au cremes, souffles, floating islands, custards, baked Alaskas, ice creams, parfaits, frappes, brulets and ices.

A baked custard is a stand-by in a hospital but it must be smooth as velvet and soft as silk to be good. With a touch of wine it is worthy of the most ardent gourmet. But often the custard has been baked at too high temperatures or for too long.

The dietitian has the culinary heritage of the past plus the scientific advances of the present to help her in the job of serving quality food. But in the final analysis, she is the determining factor of whether or not the food will be poor, mediocre or exceptional in quality. ■



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Predict Shortage of Eggs

Poultry specialists at the University of Missouri predict an egg shortage this fall, accompanied by sharply higher prices.

In view of the impending shortage and increasing price of eggs, John M. Welch, Missouri extension restaurant specialist, suggests that quantity food service operators may want to:

1. Review menus for the possible substitution of more plentiful foods for egg and egg-rich dishes.
2. Check present recipes and production practices for possible substitution of frozen and dehydrated eggs or the reduction of egg content.
3. Check stocks and futures on processed eggs.
4. Provide for priorities to place various plans of action in effect at successive levels of the rising cost of eggs.

Planning now, Mr. Welch says, will help quantity food service operators hold the line on food cost during the period of higher prices and scarcity. ■



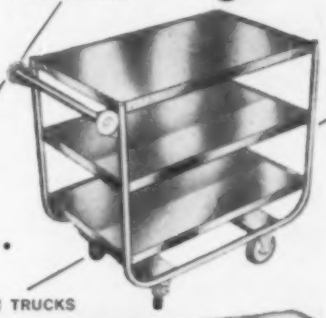
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Fried Chicken Doesn't Have To Be Fried

Oven methods of frying chicken mean patients can enjoy this popular dish without added work for the dietary department

CHICKEN, in plentiful supply during most of the year, is a menu item high in patient appeal. Traditional fried chicken, unfortunately, is not readily prepared for quantity service. The food industry, however, has developed several modifications that can be used successfully in large quantities.

One method suggested by Catherine Turner, assistant professor of home economics at the University of Alabama, is to brown the chicken in fat and then finish it in the oven in a sauce or other liquid.

Tender and tasty chicken can be prepared by lining the pan with aluminum foil, adding a cup of water to the pan, and then sealing the pan with foil. The chicken is then placed in a 350 F. oven and allowed to steam for 30 to 40 minutes or until tender.

Other liquids, Miss Turner suggests, can be used to finish the browned chicken. Examples are sour cream or condensed celery, mushroom or tomato soup.

If a slightly sweet taste is desired, the home economist suggests using a jelly such as apple, currant or cranberry sauce as the liquid in steaming. The jelly should be melted first in a double boiler.

Miss Turner also recommends a mild barbecue sauce to be used with either fryers or broilers. It omits many spices included in most sauces but produces a mild, pleasing and flavorful chicken. This sauce can be used to brush chicken that is being oven fried or to braise chicken that has been browned.

A new method of oven-frying chicken is being promoted by several concerns. Here is their easy formula:

1. Dip cut-up broiler-fryers in undiluted evaporated milk.
2. Roll in seasoned corn cereal crumbs.
3. Bake in foiled lined pan at 350 F. for one hour or until tender. There will be no need to cover or turn the chicken.

For each 12 cut-up 2½ pound broiler-fryers, use 1½ quarts of evaporated milk and four packages (9½ ounces each) of corn cereal crumbs seasoned with 1/3 cup salt, 1½ teaspoons pepper, and 2 tablespoons of monosodium glutamate.

Smothered chicken is another easily prepared, popular entree. The U.S. Department of Agriculture suggests this recipe:

1. Brown flour-dredged, disjointed chicken in hot vegetable shortening.
2. Sprinkle generously with salt and pepper, sauteed onions, diced green pepper, and sliced celery.
3. Add enough water or chicken bouillon to create steam.
4. Cover tightly and bake in a moderate oven for one hour.
5. Prepare medium thick gravy from drippings and combine the cooked chicken with gravy. Keep warm until serving time. ■

OVEN FRIED CHICKEN



BARBECUE SAUCE

Yield: Approx. 3 qts.

Ingredients	Amount
Oleomargarine	1 lb.
Salad dressing	1 qt.
Mustard, prepared	6 ozs.
Vinegar	2 qts.
Lemons, juice only	6
Salt	1 tsp.
Pepper	1 tbsp.
Ketchup	1 cup

Method

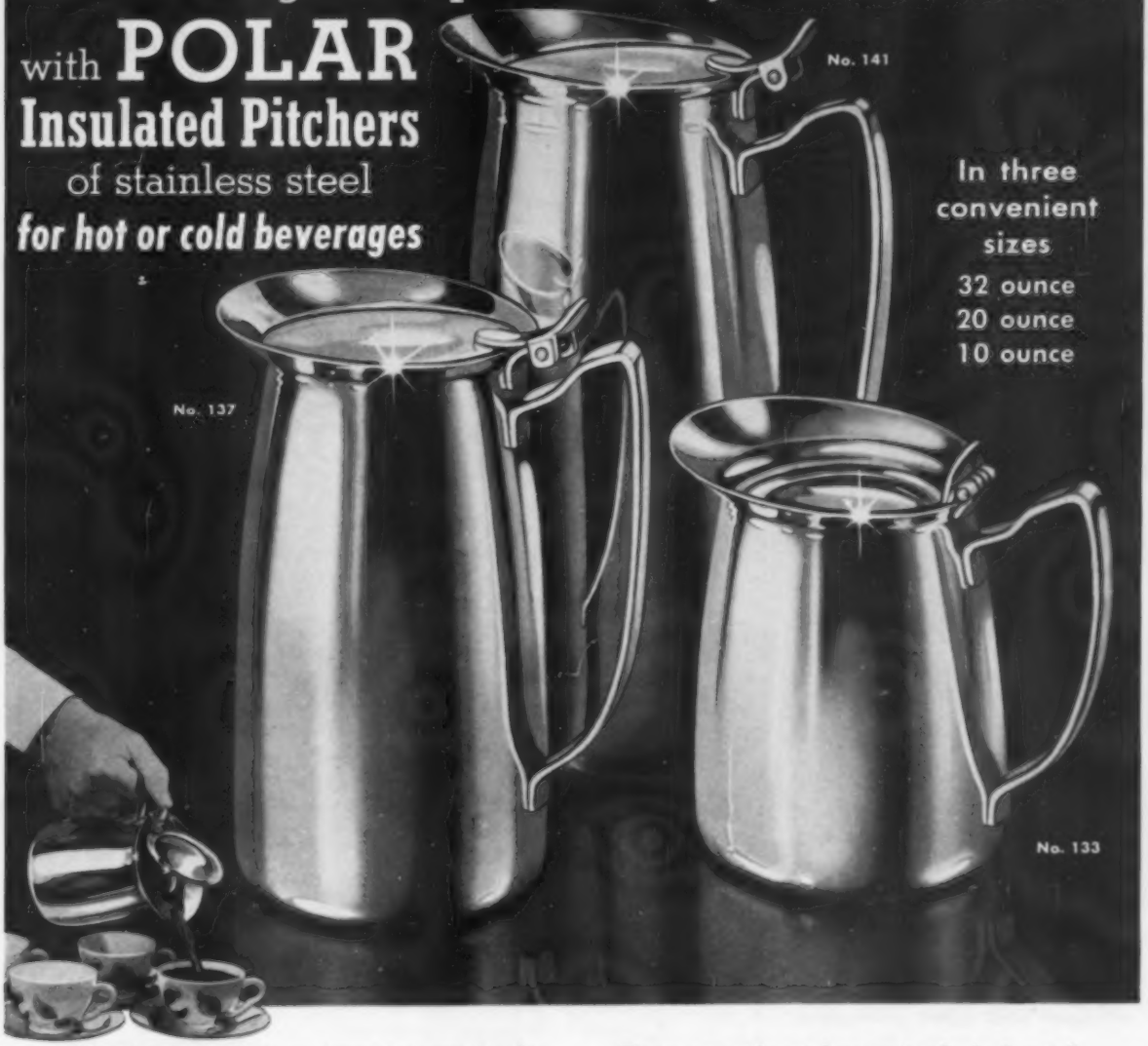
1. Heat margarine, salad dressing, and mustard together until they melt and blend.
2. Add vinegar, lemon juice, salt, pepper and ketchup and mix well.
3. Add to browned chicken, and seal pan with aluminum foil.
4. Complete cooking by allowing to braise in a 350 F. oven for 30 to 40 minutes or until very tender. Serve over rice.

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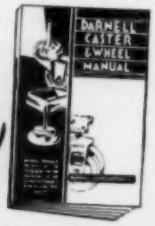
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Put Those Mental Notes in Writing Before They Get Lost in Your Mind

G. William Peffers

MAKE a mental note of it is an expression often heard among hospital supervisors — who should know better. After all, a mental note is no better than the memory it's filed in, and, besides, nobody else can read it.

Regardless of the established systems, procedures and standards, a hospital food service department cannot be fully efficient unless there is adequate supervisory follow-up communications. One way to establish effective communications is through the use of *written self-reminders.* I believe that every supervisory training program should emphasize their importance.

There are numerous hospital food supervisory job classifications: kitchen supervisor, tray assembly supervisor, cafeteria supervisor, diet therapy supervisor, and so forth. A candidate is accepted for a supervisory position on the basis of the potential shown by his experience and academic background. The candidate either has worked his way up through the ranks and is promoted from within or is hired directly from the outside. Regardless of the source of training preparatory to a supervisory job, the greatest failing in actual performance results from neglect in communications.

A food supervisor has a lot to think about and a lot to remember and follow up on any one day. Each supervisor has to perform some task or at least should know something about each one of the following phases in food work: purchase specifications, purchasing procedure, receiving, storing, inventory control, requisitioning and issuing, preparation, portion control, food distribution and service, personnel timekeeping, scheduling and training. Effective coordination of these varied phases is dependent upon communications.

Recently I read a form used by an industrial company to review its supervisors' performance. The form listed the following eight elements under which to grade or rate performance:

1. Ability to plan and organize
2. Ability to direct and develop men
3. Control of operations and cost
4. Judgment and decision
5. Acceptance of responsibility
6. Job knowledge
7. Ability to improve methods
8. Ability to cooperate with other departments

Under each element listed on the form, there are five brief descriptions of what might be considered poor, fair, average, good and excellent performance. Although the elements and descriptions are basically comprehensive, not one description indicated or emphasized that a good or excellent supervisor should write things down rather than rely on memory. However, there is not one element listed whereby top performance would be probable without putting to practice *written self-reminders.*

Even a genius can forget. So, unless the supervisor, in addition to being a genius, has a photographic mind and never forgets, he should develop the habit of keeping scratch paper and pencil in his pocket at all times, write notes, and follow up on them habitually. It is better to write too many notes than none at all. ■

Mr. Peffers is director of the dietary department at Michael Reese Hospital and Medical Center, Chicago.



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Menus for July 1960

1

Grapes
Scrambled Eggs

•

Fried Trout
Buttered Potatoes
Green Peas
Under the Sea Salad
Hot Rolls
Peach Shortcake

•

Cold Plate:
Tuna Salad
Potato Chips
Pickles
Chocolate Pudding

2

Grapefruit Half
Cheese and Eggs

•

Chicken Pie
Baked Sweet Potato
Kale
Celery and Pickle Salad
Strawberry Gelatin

•

Liverwurst, Salami
Sliced Cheese
Potato Salad
Sliced Kosher Dill Pickles
Yellow Cake With
Chocolate Frosting

3

Bananas
Hard Cooked Eggs

•

Baked Ham
Escalloped Potatoes
Asparagus
Mixed Green Salad
Coconut Pie

•

Beef and Macaroni
Casserole
Brussels Sprouts
Pickled Beets
Fruit Cup

4

Fresh Pears
Scrambled Eggs, Bacon

•

Fried Chicken
Corn Pudding
Buttered Spinach
Hot Rolls
Jellied Cranberry Salad
Ice Cream

•

Cold Plate:
Baked Ham
Potato Salad
Pickles and Olives
Vanilla Pudding With
Sliced Peaches

5

Baked Fresh Apple
Bacon

•

Broiled Liver,
Onion Gravy
Rice
Buttered Spinach
Waldorf Salad
Ice Cream

•

Vegetable Soup
Ham Croquettes
Noodles
String Beans
Spiced Peach Salad
Cherry Cobbler

6

Sliced Orange
Scrambled Eggs

•

Roast Turkey
Dressing and Gravy
Orange-Glazed Sweet
Potatoes
Green Peas
Peach With Cottage
Cheese Salad
Pumpkin Pie

•

Meat Loaf, Tomato Sauce
Mashed Potatoes
String Beans
Congealed Fruit Salad
Cookies

7

Grape Juice
French Toast, Sausage

•

Barbecued Beef, Buns
French Fried Potatoes
Butter Beans
Fruit Salad
Ice Cream

•

Smoked Tongue
Buttered Hominy
Fresh Kale
Hot Biscuits
Apple Pie

8

Grapefruit Half
Scrambled Eggs

•

Fried Trout
Mashed Rutabagas
Oven Browned Potatoes
Coleslaw
Cornbread
Pineapple Chiffon Pie

•

Salmon Casserole
With Biscuit Topping
Whole Kernel Corn
Peas and Carrots
Cottage Cheese Salad
Gingerbread

9

Pear Nectar
Soft Cooked Eggs

•

Hamburger Steak
Oven Browned Potatoes
Stewed Tomatoes
Grated Carrot and
Pineapple Salad
Fruited Gelatin

•

Roast Lamb,
Mint Jelly
Rice
Buttered Green Peas
Pear Salad With
Grated Cheese
Lemon Meringue Pie

10

Grapes
Scrambled Eggs, Bacon

•

Smithfield Ham
Corn and Butter Beans
Spinach
Spiced Peach Salad
Hot Rolls
Caramel Peach Float

•

Hungarian Goulash
Buttered Broccoli
Lettuce and Tomato
Wedges
Blueberry Pie

11

Tangerine
Bran Muffins, Sausage

•

Pot Roast With
Vegetables
Cabbage
Cornbread
Spiced Cucumbers
Ice Cream

•

Chicken Curry
Baked Sweet Potato
Kale
Grapefruit Section Salad
Baked Custard

12

Orange Juice
Hot Cinnamon Buns

•

Southern Fried Chicken
Mexican Corn
Seasoned String Beans
Grapefruit and Pineapple
in Orange Gelatin Salad
Ice Cream

•

Grilled Luncheon Meat
Baked Beans
Mixed Vegetables
Sliced Tomato Salad
Bread Pudding
With Raisins

13

Bananas
Pancakes, Sirup

•

Breaded Veal Cutlet,
Tomato Sauce
Baked Potato
Buttered Carrots
Apple Salad
Baked Custard

•

Braised Pork Chop
Mashed Sweet Potatoes
With Marshmallows
Fresh Collards
Pickle Relish
Deep Dish Apple Pie

14

Tomato Juice
Scrambled Eggs

•

Spaghetti With
Meat Sauce
French Bread
Tossed Green Salad
Lime Sherbet

•

Braised Cube Steak
Black Eyed Peas
Scalloped Tomatoes
Molded Cranberry and
Orange Salad
Banana Shortcake

15

Hot Spiced Applesauce
Soft Cooked Eggs

•

Baked Rock Fish
Parsley Potatoes
Buttered Carrots, Peas
Corn Sticks
Coleslaw
Lemon Gelatin With
Whipped Topping

•

Salmon Cakes
Mashed Potatoes
Broccoli
Head Lettuce Salad,
1000 Island Dressing
Coconut Cake

16

Stewed Prunes
Scrambled Eggs, Bacon

•

Roast Beef
Buttered Potatoes
Asparagus
Cabbage-Carrot Salad
Cornbread Squares
Cookies, Ice Cream

•

Ham-Stuffed Peppers
Whole Kernel Corn
String Beans
Tomato, Cottage Cheese
Salad
Pineapple Pie

17

Orange Sections
Waffles, Sirup

•

Roast Pork
Paprika Potatoes
Squash and Onions
Mixed Vegetable Salad
White Cake With
Jam Topping

•

Chicken Chow Mein
Chinese Noodles
Buttered Rice
Buttered Peas
Waldorf Salad
Sliced Peaches

18

Peach Nectar
Baked Eggs

•

Smothered Steak
Hashed Brown Potatoes
Spinach, Lemon Sauce
Celery and Pickle Sticks
Gingerbread-Apple
Upsidedown Cake

•

Chili con Carne
With Kidney Beans
Asparagus, Cheese Sauce
Pepper Slaw
Garlic French Bread
Orange Cake

19

Apricot Slices
Scrambled Eggs

•

Baked Chicken
Succotash
Harvard Beets
Perfection Salad
Pineapple Sherbet

•

Chinese Omelet
Field Peas
Broiled Tomato
Spiced Pear Salad
Peanut Brittle Bread
Pudding

20

Stewed Apples
Sausage Patties

•

Broiled Lamb Chops
Candied Yams
Creamed Peas
Head Lettuce,
French Dressing
Fruit Cup

•

Roast Veal
Corn on the Cob
Buttered Lima Beans
Tomato Salad
Lemon Pudding

21

Orange, Grapefruit Juice
French Toast, Bacon

•

Hamburger Patties
Spanish Rice
Buttered Spinach
Molded Cucumber Salad
Peach Cobbler

•

Chicken Fricassee
Buttered Cauliflower
Pear Salad
Devil's Food Cake

22

Baked Spiced Pears
Pancakes, Sirup

•

Baked Haddock
Baked Stuffed Potato
Seasoned Kale
Carrot, Celery Strips
Cornbread
Cherry Pie

•

Cold Plate:
Tuna Salad
Potato Sticks
Cranberry Jelly With
Orange Slice
Peach Tapioca

23

Tangerine Juice
Ham, Muffins

•

Country Style Steak
Buttered Noodles
Brussels Sprouts
Peach Salad With
Cream Cheese
Caramel Custard

•

Macaroni and Cheese
With Sausage Cakes
Broccoli With Cream
Sauce
Sliced Tomato Salad
Fruit Cocktail and
Gelatin Cubes

24

Prune Juice
Scrambled Eggs

•

Barbecued Chicken Legs
French Fried Potatoes
Asparagus in Pimiento
Ring
Molded Apricot,
Nut Salad
Sliced Pineapple

•

Cheese Fondue
Buttered Vegetables
Congealed Grapefruit,
Cucumber Salad
White Cake With Butter-
scotch Sauce and Pecans

25

Bartlett Pears
Cheese and Eggs

•

Rib Roast of Beef
Parsley Rice
Buttered Squash
Molded Apple Salad
Ice Cream

•

Chuckwagon Steak
Noodles
Stewed Tomatoes
Tossed Green Salad
Butterscotch Pie

26

Honeydew Melon Wedge
Creamed Ham Omelet

•

Corned Brisket
Cabbage
Buttered Potatoes
Pickled Beets
Corn Muffins
Jelly Roll

•

Club Sandwiches:
Sliced Turkey, Bacon,
Lettuce, Tomato
Potato Chips
Home-Style Pickles
Banana Pudding With
Meringue Topping

27

Cranberry Juice
Scrambled Eggs, Sausage

•

Broiled Steak
Julienne Potatoes
Buttered Broccoli
Lettuce Wedge With
Garlic Dressing
Hot Buttered Rolls
French Apple Pie

•

Cold Plate:
Chicken Salad on
Lettuce, Sliced Tomato
Party Pickles
Cheese Breadsticks
Brownies With Nuts

28

Pineapple Juice
Raisin Muffins

•

Crab Cakes, Scallops
Buttered Potatoes
Wax Beans, Cheese Sauce
Tomato, Cucumber Slices
French Rolls
Peach Shortcake

•

Oven Browned Shortribs
au Gratin Potatoes
Hanover Greens
Deviled Egg Salad
Orange Sherbet

29

Bananas
Waffles, Sirup

•

Shrimp Creole
Buttered Rice
Tiny Green Peas
Waldorf Salad
Chinese Chews

•

Breaded Oysters and
Shrimp
French Fried Potatoes
String Beans
Tomato Aspic
Spoonbread
Lemon Sponge Pudding

30

Sliced Peaches
Soft Cooked Eggs

•

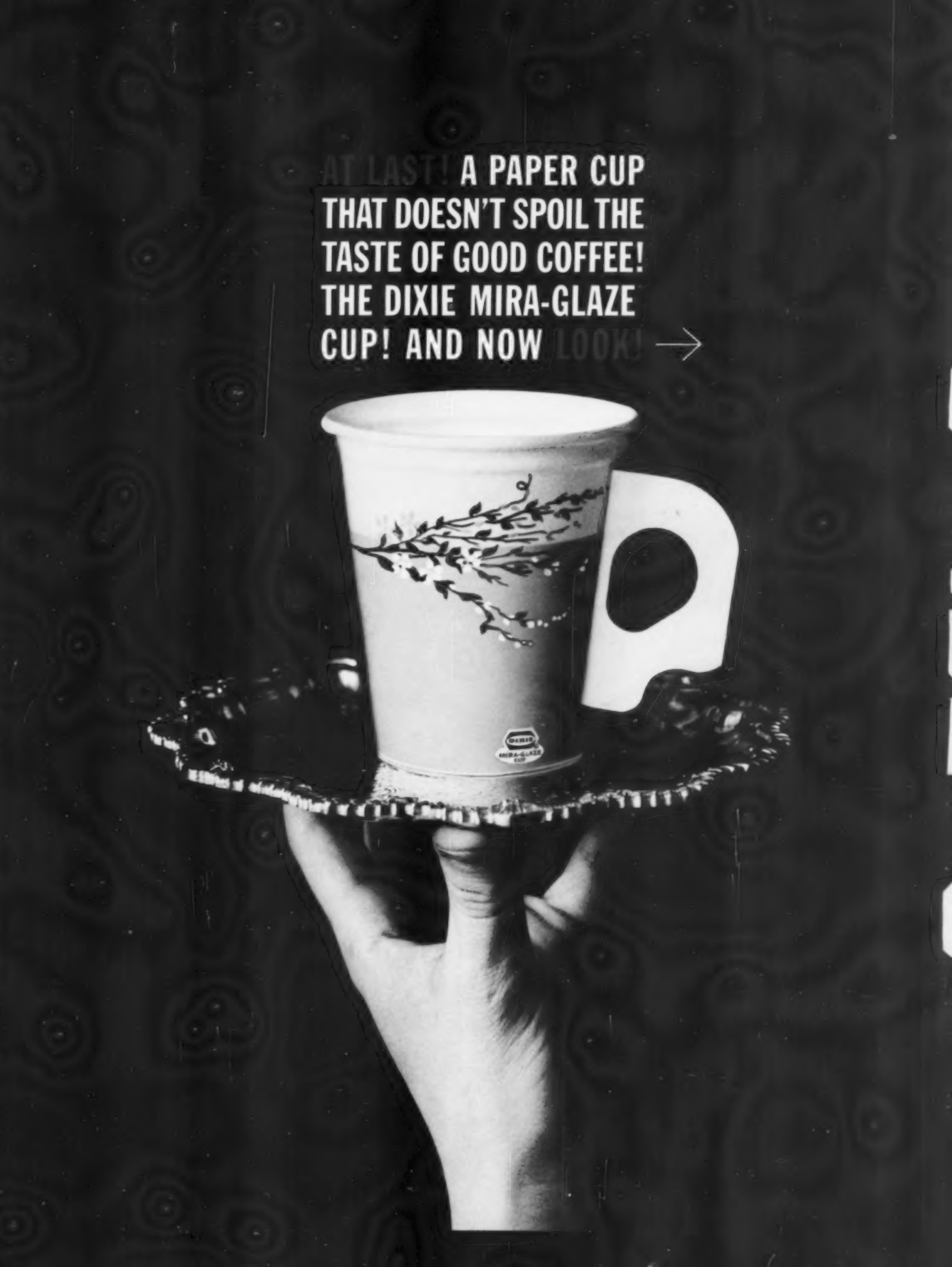
Liver Chips,
Onions and Gravy
Rice
Parmesan String Beans
Spiced Apple Rings
Chocolate Cobbler

•

Salmon Loaf
Creamed Potatoes
Tiny Whole Carrots
Pineapple Spears
and Pepper Ring Salad
Lemon Bisque

31 Baked Apple, French Toast • Baked Ham, Escalloped Potatoes, Stewed Tomatoes, Hot Rolls, Fruit Salad, Ice Cream • Beef and Macaroni Casserole, String Beans, Cornbread, Spiced Cucumbers, Gingerbread

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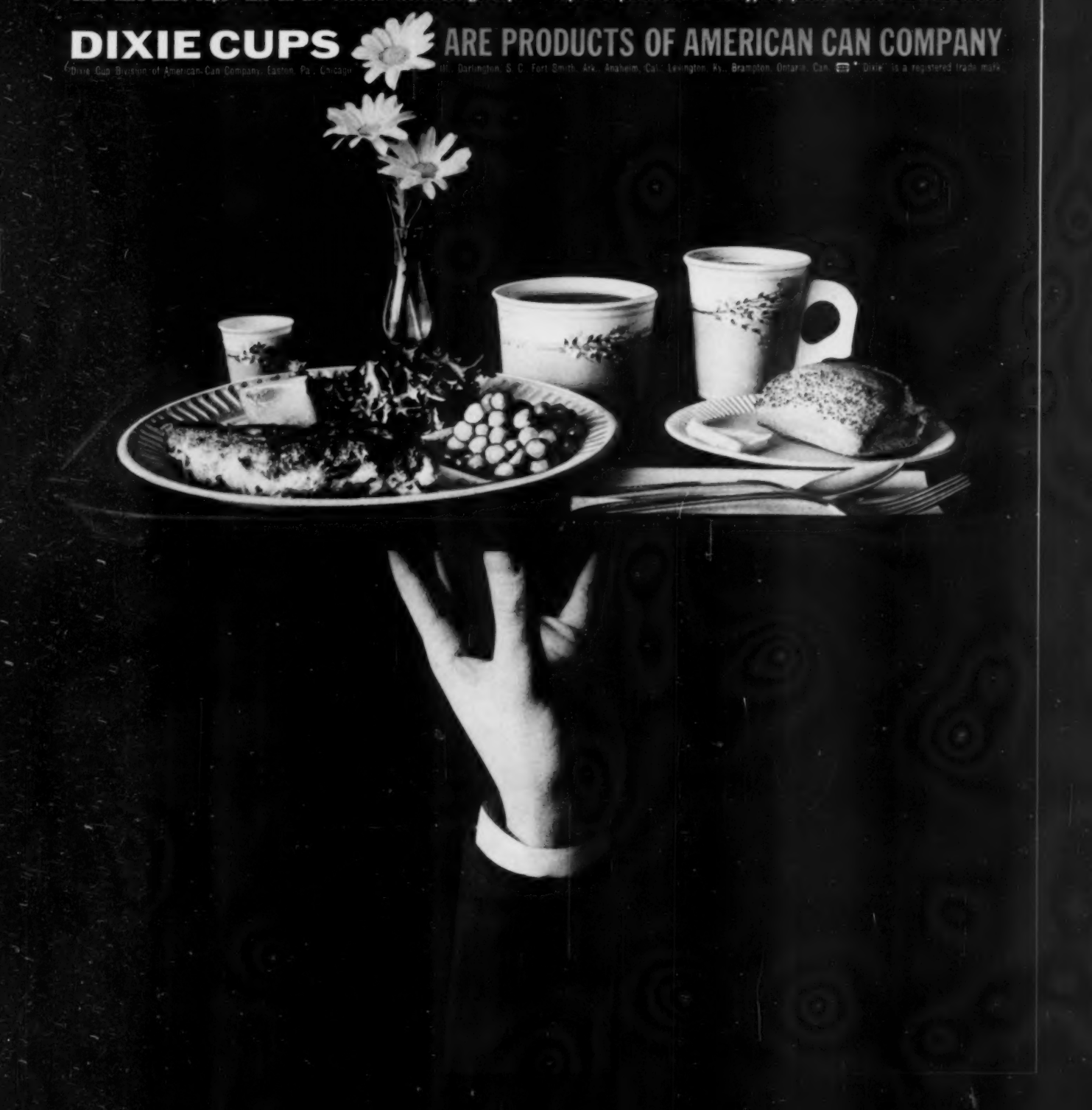

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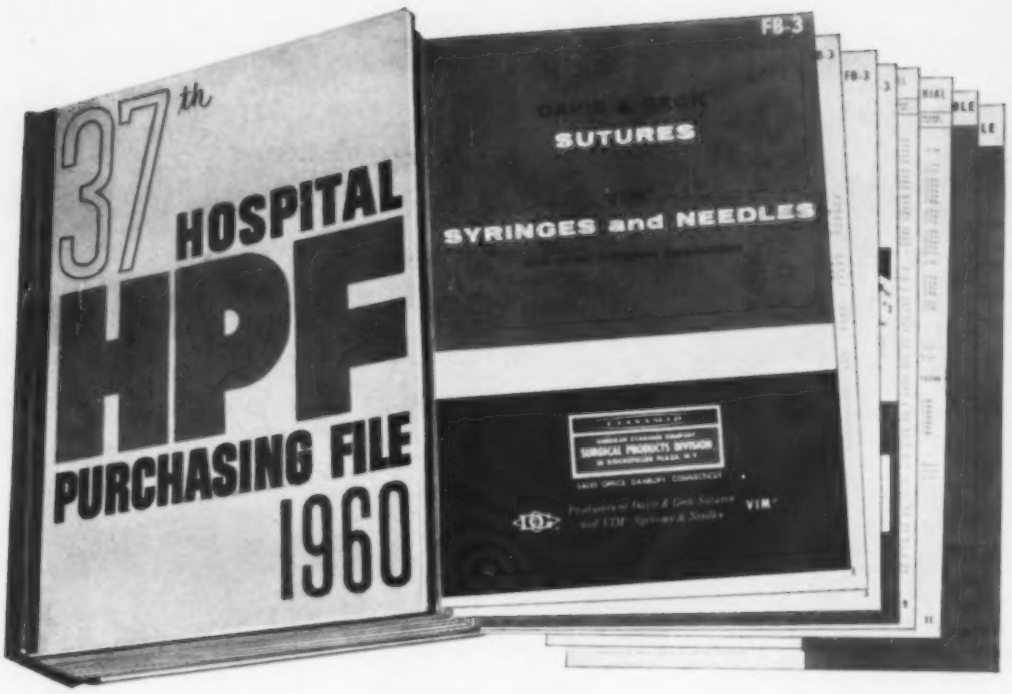
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The Engineer Takes Friction Out of Planning

If his advice is sought, the engineer can help the administrator and department heads plan for alteration, new equipment, and more effective operation of the hospital's physical plant

Leland J. Mamer

THE engineer assumes responsibility for the operation and maintenance of the largest investment in the hospital — the physical plant and all its equipment.

In accepting this responsibility, the engineer becomes a key person in the successful operation of the hospital. He is involved with every department and area of the hospital, professional and nonprofessional, and can provide valuable advice and information to all department heads and the administrator.

The administrator should utilize the services of his engineer whenever there is any planning for alterations, remodeling or new additions. Why? Because the engineer is familiar with all aspects of the physical plant, including the utility services, and knows what can or cannot be done. Through his experience and knowledge he can properly advise on whether certain changes or alterations can be made and how they can best be done. He can also advise whether or not existing equipment and utility services are adequate and, if not, what should be done to meet the new conditions.

Too often the engineer is ignored, with the result that new situations prove to be unworkable. This is often true even when consulting engineers and architects are involved. The administrator should realize that his engineer must know all phases of operation and maintenance of the physical plant and is best qualified to give the necessary information whenever any planning is being done.

The engineer should work with the administrator to develop specifications for interior building finishes as well as equipment. Building finishes include those used in basic construction as well as interior finishes that will mean low maintenance for years to come. Too often the basic structure and finishes involving floors, walls and ceilings meet only minimum standards, which means low initial cost of construction but high maintenance costs after a few years.

Examples of improved interior finishes that the engineer might recommend include: ceramic tile floors and walls with an enamel painted acoustical tile ceiling in utility rooms, janitor's closets, pantries and bathrooms instead of cement floors and resilient tile with painted plaster walls and ceilings; a 48 inch to 54 inch dado with plastic material or ceramic blocks in all corridors instead of painted walls from floor to ceiling; stainless metal corner guards to reduce damage from trucks, wheel chairs, and similar equipment.

The engineer can also advise which equipment design will result in longer life, easier cleaning, and lower maintenance. Too often, for example, baked enamel cabinets are used in areas where there is considerable moisture, or stainless steel is used in such areas with an interior framework made of hot dipped galvanized iron. Both of these can rust out in 5 to 10 years and are difficult and expensive to replace.

He can best determine such matters as whether steam, gas or electricity is most economical and best suited for the area and equipment involved in planning for utility services. He should be familiar with the advantages and disadvantages of such fixed equipment as boilers, firing equipment, heat exchangers, and heaters; methods of heating involving steam or hot water and types of controls for each; ventilating and air conditioning systems; types of filtering equipment such as mechanical or electronic and throw-away or permanent; electrical and piping systems, and plumbing fixtures.

His experience and knowledge of this and similar equipment will help determine what is best suited to the hospital's needs, what is most economical to operate and maintain, and what is required to provide for expansion of the hospital as well as to maintain standards throughout the hospital. **Too often, planning for the future is ignored when the hospital is considering the basic, built-in equipment and systems necessary for its long-range operation.**

If there is to be considerable remodeling or modernization plus new additions, the administrator and the

---

At the time this article was prepared, Mr. Mamer was assistant to the executive director, St. Luke's Hospital, New York. He is now director of plant and maintenance at New York University Medical Center, New York.

This article is condensed from a paper presented at a Hospital Engineering Institute, Kansas City, Mo.

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engineer can save time by setting up recommended standards for materials and equipment that can be followed from project to project with few, if any, changes. Thus, when each project is planned, the basic standards can be applied and it is necessary to consider only the special conditions in each department involved. Adoption of these standards should be done in a meeting of the administrator, the hospital engineer, the building committee, the architect, and the consulting engineers.

Once established, specifications for equipment can be written with the cooperation of the purchasing agent and kept on file for future use. A specifications committee should be set up that would include the purchasing agent, the engineer, and the department head involved. The administrator should review results to be sure the standards program is maintained. Those specifications written by the architect and consulting engineers can also be kept on file for future reference by the hospital engineer. Setting high standards in specifications and having them on file can save much time as well as future maintenance costs for the hospital.

Working with department heads is another important function of the engineer. Areas in which they should work together include: training employes in proper operation and maintenance of equipment, determining whether equipment has performed efficiently, setting procedures for routine maintenance, and recommending replacement or purchase of new equipment. This latter is especially important because often costly changes, overtime wages, and temporary loss of service can be avoided if the engineer is consulted before the equipment is installed.

The administrator should encourage cooperation between the engineer and department heads because it will result in more efficient operation and lower maintenance costs.

The administrator has a right to be upset when lack of proper planning and cooperation affects the budget and upsets the operation of the department. He should, therefore, insist that his engineer work with the department heads whenever new equipment or physical changes are being considered within a department. Since the engineer should have the responsibility of maintenance of equipment, and is interested in economy as well as efficiency, he certainly should be involved in setting up planning and specifications for all equipment.

Another area in which the administrator should depend on his engineer as a part of the administrative team is the development of a fire and safety program for the hospital. The engineer is usually the key person on the fire and safety committee because he is best qualified to carry out the requirements of such a program and the men in his department usually form the basis of the fire team. To be successful this program must involve all departments in the hospital and the administrator must support such a program fully. The engineer and his department are expected to carry out any recommendations or changes that are necessary to keep accidents and fire hazards to a minimum. Thus, he should be on the inspection committee to suggest remedies as well as recommendations for correcting any hazardous condition, in patient areas as well as all departments and public areas throughout the hospital. ■



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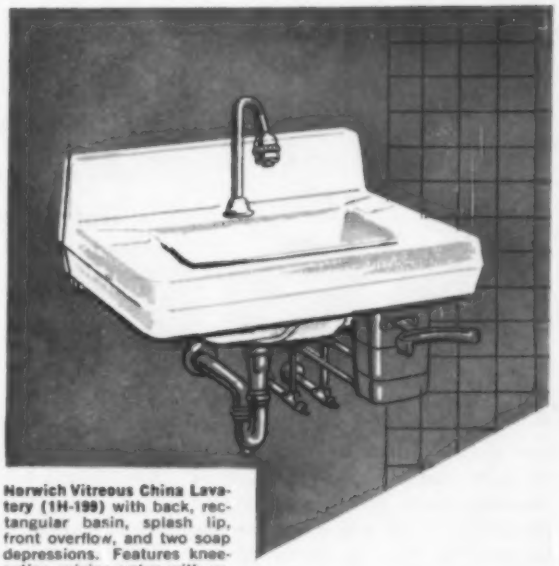
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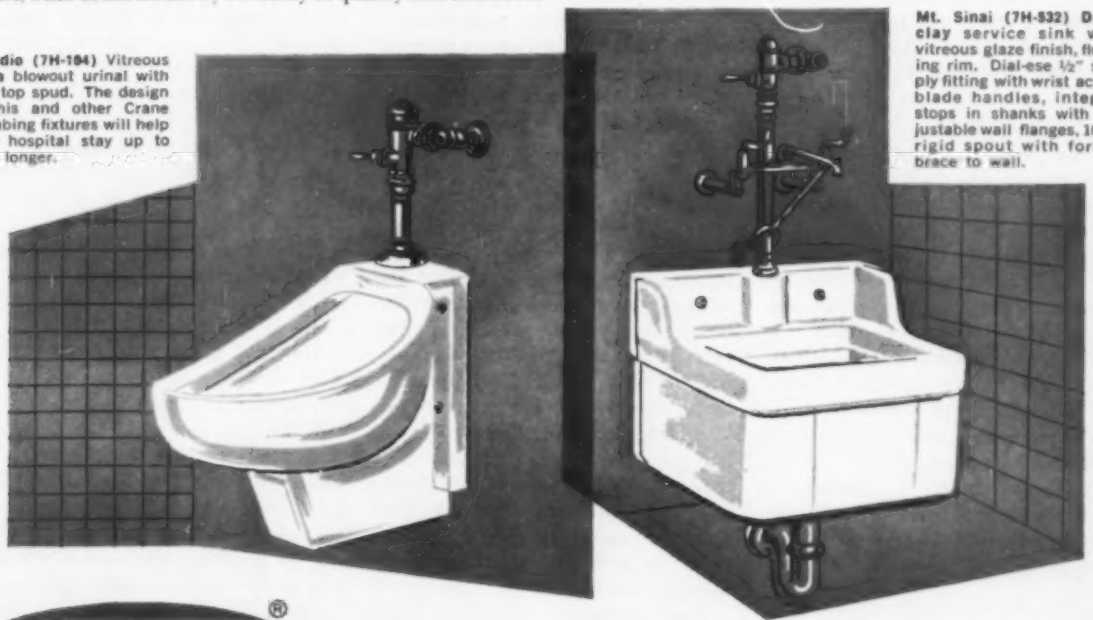
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Patients and Pillows Infect Each Other

In this section of his series on technics of disinfecting pillows and blankets, the author outlines problems of cross-contamination and describes measures that have been taken to prevent the spread of infection

Wolfgang Haas

INASMUCH as pillows are generally covered only with cotton pillow covers, which are not a very effective barrier to the passage of microorganisms, both the ticking and the filling of the pillow can become infected by microorganisms passing through and rubbing off the pillowcase.

These microorganisms may have come from a skin infection — possibly the ordinary acne. They may have come from the respiratory tract of the patient occupying the bed when he coughed, sneezed or merely exhaled. Since a considerable percentage of all patients who are admitted to hospitals carry, or quickly become nasal carriers of, pathogenic organisms, most pillows will eventually become infected. This is particularly true because some pathogens, including some of the staphylococci, can survive on blankets, on mattresses, on the floor, or in dust for a long time. Finally, the pillow can also collect its share of the microorganisms that are found in the air of nursing units.

Although reports on studies of contamination of pillows by pathogens could not be found in the literature, it seems reasonable to consider them both highly contaminated and active in disseminating infection. In one study of hospital bedding, Kaye found a higher bacteria count on soiled pillowcases than on used wool blankets or soiled sheets.[1] Walter has also reported high counts of microorganisms on pillowcases.[2]

Once the pillow has become infected, it expels microorganisms, — some innocuous, some pathogenic — every time the patient moves his head or a solicitous attendant fluffs it for him. Thus the hospital has added to the infectious matter to which the patient is exposed.

To protect patients and pillows from each other, bacteriologically speaking, we can do one of two things. The whole pillow can be disinfected after each use so that the microorganisms that it collected while being used by one patient are not passed on to the next. The other possibility is to protect the pillow so that it does not become contaminated. The feasibility of disinfecting the pillow, as a whole, by technics other than washing are considered elsewhere. **In this section we will consider the possibility of washing the pillow or protecting it with a cover that can be washed.**

Washing. Routine washing of foam rubber pillows would meet with a number of difficulties. An American Institute of Laundering report says that they can be washed like wool, at low temperatures. Low-temperature washing without the use of a chemical disinfectant has been shown, in the section of this article published in the May issue of The MODERN HOSPITAL, to be an inadequate disinfecting technic for blankets. It would presumably be likewise inadequate for pillows. Concerning chemical agents, however, Perkins says:

"All articles made of rubber . . . are highly susceptible to attack and deterioration by chemical agents . . . . The following substances . . . will destroy the usefulness of all articles made of rubber: . . .

"Phenols and cresols . . . cause stickiness and disintegration.

"Quaternary ammonium compounds . . . cause tackiness . . . ."[3]

The A. I. L. report points out another difficulty in the use of foam rubber pillows. It says:

"Drying rubber pillows is a problem. If placed in a tumbler and allowed to reach a temperature of 150 F. or over, they will become sticky. At the same time, if tumbled, they will get scuffed. Thus, rubber pillows must never be exposed to heat or mechanical action. About the only answer is air drying."[4] (*Cont. on p.* 154)

Continuing an article on disinfection of pillows and blankets condensed from a master's thesis prepared by Mr. Haas as part of the program in hospital administration at the University of Michigan. The first section appeared last month. The article will be continued next month.

Mr. Haas is administrative assistant and office manager of Sherman Oaks Community Hospital, Sherman Oaks, Calif.

[1]Kaye, S.: The Use of Ethylene Oxide for the Sterilization of Hospital Equipment. J. Lab. and Clin. Med. 35:823, 1950.

[2]Walter, Carl W.: Environmental Sepsis. Mod. Hosp. 91:69 (December) 1958.

[3]Perkins, J. J.: Principles and Methods of Sterilization. Springfield, Ill.: Charles C Thomas, 1956.

[4]American Institute of Laundering: Pillow Processing Practices. Service Bulletin No. 490-A (January) 1956.

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It would seem, therefore, that foam rubber pillows cannot readily be disinfected by washing because of the destructive effect of the preferred disinfectants and because of the practical problems of air drying a very considerable mass of material in the hospital laundry.

The previously cited A. I. L. report states that pillows filled with feathers may be washed by a technic based on a wool washing procedure. Presumably the same disinfectants that are used for wool blankets could be used for feather pillows, although no reports of such use have been found.

The direct costs of washing pillows would depend on the costs in the laundry. These would be different in each hospital. As an example, the cost figures for all Cleveland hospitals for 1958 would give an average direct cost of approximately 12 cents per pillow. If a quaternary ammonium compound were used as the disinfectant, the cost for this would be less than one cent per pillow. Total costs cannot be computed in the absence of depreciation figures. There is a widely prevalent, though unsubstantiated, belief that repeated washing would greatly reduce the useful life of the pillow.

One manufacturer suggests that pillows filled with dacron may also be washed by a technic based on wool washing procedures, that is, at low temperatures with gentle mechanical treatment.

Cost Depends on Laundry

Again, the costs of a method of disinfecting dacron filled pillows by washing them would depend on the direct costs of the laundry, including the cost of the disinfectant used, and the depreciation caused by the washing. Since this latter figure is unknown, total cost figures cannot be given.

Pillow Covers. Various materials are available for covering pillows. The basic requirement for a pillow cover is that it prevents the passage of microorganisms from the environment to the pillow and from the pillow to the patient.

One material that can be used is a flexible and translucent sheeting that is fabricated into pillow covers. These covers have a zipper closure and the manufacturer reports that this material can be washed with warm water and a mild soap or detergent and can be wiped with any of the regular disinfectant solutions.

Another material that can be used is polyethylene film. The fact that this is being used to package presterilized items for use in the hospital is evidence of its effectiveness in preventing the passage of microorganisms. This material could be readily used on a disposable basis since it can be made into bags from tubular material at a cost of approximately 3 cents each.

Pillow covers which are impervious to moisture, such as those made of plastic sheeting or polyethylene do not meet with patient acceptance. According to nurses who have worked in hospitals using such covers, they make the pillow damp, warm and rather hard.

A possible modification of the use of impervious pillow covers is to place an additional layer of material between the pillow cover and the pillowcase. This was tried with cotton bath blanket material and was found to be satisfactory, though not completely comfortable.

Another solution to the problem of protecting the patient and the pillow from contamination by each other is suggested by Colbeck's study of the role of fomites in spreading infection.[5] Essentially, he set up a barrier which, though not impervious, reduced the passage of microorganisms by preventing the production and the passage of dust (which could act as a carrier for microorganisms), and by killing many of the microorganisms which came in contact with the barrier. Although his work was concerned with mattresses, it seems that the results may be applied, by analogy, to pillows.

Each mattress was provided with an additional cotton ticking cover. After the discharge of the patient using the bed, the cover was washed. In the final rinse it was impregnated with mineral oil and a quaternary ammonium compound which remained in the material as a persistent bactericidal agent. This study confirmed the work of others who had shown that oiling textiles would prevent dust and act as a barrier to its passage and that the quaternary ammonium compounds were persistent bactericidal agents. This latter effect is not operative on dry dust. However, when droplets of moisture reach the treated material, as occurs when a patient contaminates his pillow from his respiratory tract, the latent bactericidal reserve is mobilized. Colbeck summarizes by saying:

"It is considered that the use of mattress covers and that the oiling of these covers and their impregnation with an antiseptic is of value in preventing spread of infection to mattresses and will also reduce aerial infection, which is dangerous alike to staff and patients.

"It is considered that all mattresses in hospitals should be covered by a well designed thick textile cover impregnated with oil and an antiseptic, and that the covers should be laundered and retreated on the discharge of all patients. However, owing to the possibility of infection passing this barrier, mattresses should be disinfected on the discharge of all frankly infected cases."[6]

Method Applicable to Pillows

If we read "pillow" for "mattress" in these remarks (which seems reasonable, considering the similarities in material, construction and use), we seem to have an effective, convenient and inexpensive method for protecting patients from pathogens collected and spread by pillows.

No reports of skin irritation for patients or staff as a result of using a quaternary ammonium compound on textiles have been found. Rountree reported that blankets that had been impregnated with oil and cetyle pyridinium bromide were only slightly oily and had no perceptible odor.[7]

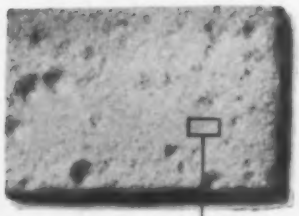
Using a cover that is disinfected rather than disinfecting the whole pillow would avoid the need for transporting a rather considerable mass of material through the hospital. Although the impermeable covers have their uses, they do not seem acceptable for general use.

The available figures indicate a cost of approximately 2 cents for mineral oil and disinfectant to impreg-

[5]Colbeck, J. C.: Studies in Hospital Infections, I. the Importance of Staphylococcal Disease. Canad. Serv. M.J. 12:563 (July-August) 1956.

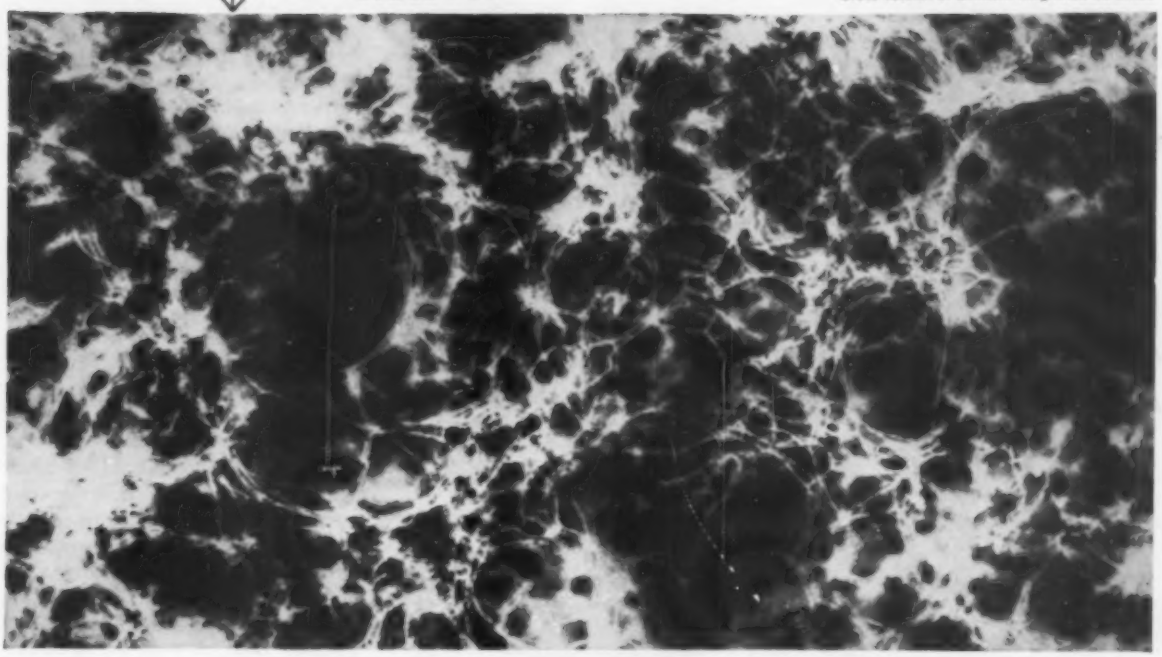
[6]Ibid.

[7]Rountree, P. M.: The Treatment of Hospital Blankets With Oil Emulsions and the Bactericidal Action of "Fixanol C" (Cetyl Pyridinium Bromide). M.J. Austral. 1:539 (April 20) 1946.



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nate a pillow cover. The costs of making, collecting and washing the pillow covers would be additional and would vary with the local costs.

Technics of Sterilization

Ethylene Oxide. A technic of sterilization which has found wider use in recent years involves the use of ethylene oxide. At ordinary temperatures this is a colorless gas, irritating to skin and mucous membranes, and capable of causing severe burns. Ethylene oxide is vigorously flammable (explosive if confined) when mixed with air in almost all proportions. For commercial or hospital use it is mixed with 80 to 90 per cent carbon dioxide or freon gas. This mixture is not flammable or explosive.

That ethylene oxide is apparently effective against all types of microorganisms seems to be a fair summary of studies conducted in this field. On the question of the effects of this gas on various materials, Newman, Colwell and Jameson report that ". . . wool, cotton, rayon, silk, felt, nylon . . . were undamaged by ethylene oxide treatment."[3] A company that has conducted a considerable amount of research on gas sterilization also lists these materials among those not injured by this gas. Also worth noting is the absence from the literature of references to damage that has been done by ethylene oxide.

This gas is used in specially designed sterilizers which provide the proper conditions of temperature and humidity and which, by proper venting to the outside of the building, allow this irritating material to be used without harm to personnel. Ethylene oxide permeates through most materials extremely well. This allows its sterilizing effect to operate throughout a pile of blankets or inside pillows.

The considerations favoring the use of ethylene oxide to disinfect blankets and pillows are: (1) effectiveness against all types of microorganisms; (2) capability of disinfecting whole pillow; (3) no wear of material.

Considerations opposing the use of ethylene oxide to disinfect blankets and pillows are: (1) considerable cost of equipment and gas; (2) blankets are not cleaned; this is esthetically unsatisfactory and may leave organic matter which will support the growth of microorganisms which may settle on the blanket when it has been given to another patient.

Moist Heat. Authorities agree that 13 minutes' direct exposure to saturated steam at 121 C. (250 F.) will sterilize the object so treated. A longer period in the autoclave is necessary to allow saturation and heating of all of the content of the autoclave to this temperature. Sterilization by steam is the technic of choice (for safety, reliability, simplicity and economy), for those materials which can withstand this treatment. The question is whether blankets and pillows are in this category.

1. Blankets. Various authorities have found that after a few exposures to steam, wool blankets had shrunk to two-thirds of their original length and had lost all fluffiness, producing a blanket that was small, hard and uncomfortable. After six repetitions of a procedure involving low-temperature washing followed by autoclaving, the wool blankets had lost 47

[3]Newman, L. B.; Colwell, C. A., and Jameson, E. L.: Decontamination of Articles Made by Tuberculous Patients in Physical Medicine and Rehabilitation. Amer. Rev. Tuber. and Pul. Dis. 71:272 (February) 1955.

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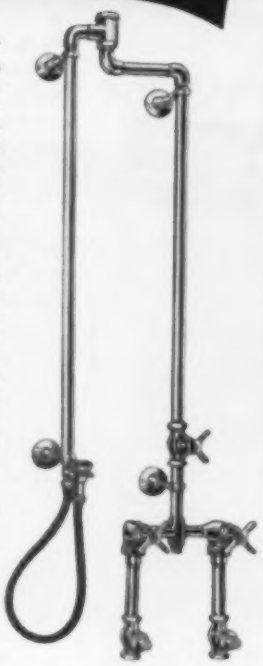
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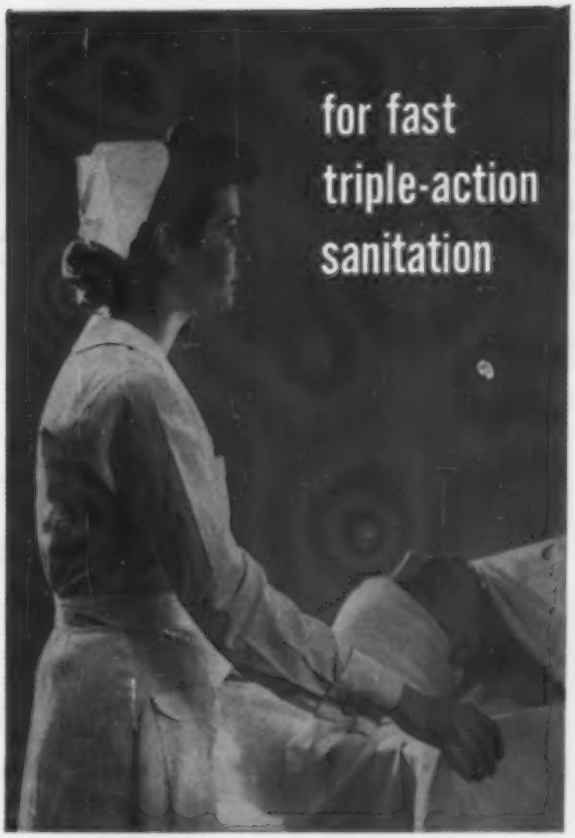


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per cent of their original area and had felted into a hard coarse material.

No reports have been found of the effect of moist heat sterilization on cotton blankets. This technic may be tentatively eliminated from consideration by the following reasoning: Steam will only sterilize clean objects or materials; therefore the blankets must be washed before being autoclaved; but high-temperature washing will disinfect cotton blankets adequately; therefore steam sterilization is an unnecessary additional step.

The manufacturers of fabrics woven from the synthetic fibers generally recommend washing and pressing at low temperatures. In view of this, and in the absence of studies of autoclaving of blankets made of the synthetic fibers, disinfection of such blankets by moist heat cannot be recommended.

2. Pillows. Perkins says that disinfection by steam has an adverse effect on foam rubber and that, ". . . repeated disinfection will result in discoloration, hardening, loss of elasticity, and tensile strength."[9]

[9]Perkins. Op. Cit.



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Feathers are classified, together with wool, as protein fibers. The response of one to a given type of treatment is a good indication of how the other would react. Since wool fibers are damaged greatly when exposed to moist heat, a similar result can be expected for feathers.

No reports have been found of the effect of steam disinfection on pillows filled with shredded dacron. Considering the fact that fabrics woven of this material must be washed and pressed at low temperatures, it seems reasonable to conclude, at least tentatively, that steam sterilization is not a suitable technic for routine disinfection of pillows filled with shredded dacron.

Dry Heat. The use of dry heat, which could be conveniently applied in the dryers of the laundry, can apparently be excluded from consideration as a technic of disinfection for blankets and pillows. Perkins states, ". . . a temperature of at least 160 C. (320 F.) should be used in dry heat methods of sterilization."[10] He says elsewhere that ". . . because of the poor penetrability and destructive effect of high temperatures employed, dry heat or hot air is entirely unsuited for the sterilization of fabrics and rubber goods."[11] Likewise, Giedt says:

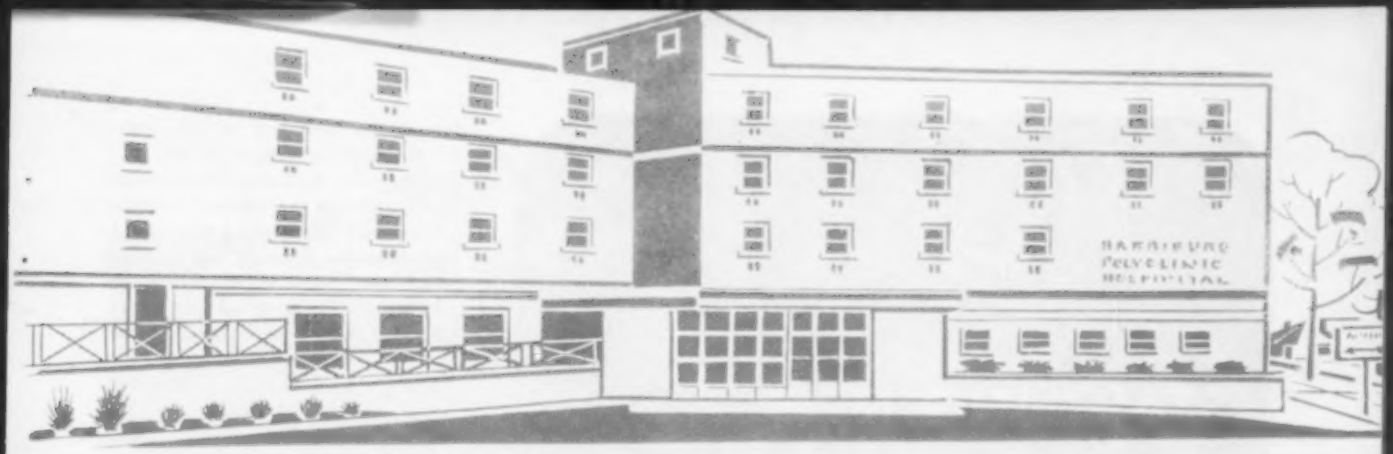
". . . the temperature and time of exposure to be used in dry heat sterilization varies considerably according to the type of material to be sterilized. For example, sterilization of instruments by this method can be accomplished in one hour's exposure at 160 C. (320 F.) because the heat conducting properties of metal are high. In contrast, the heat conducting properties of blanket material are considerably lower."[12]

The foregoing comments indicate that dry heat is not a suitable method for disinfecting blankets or foam rubber pillows. Since feathers are classed with wool in their reaction to heat, feather pillows cannot be disinfected by dry heat. The thermoplastic qualities of dacron, as illustrated by the requirement that clothes made of this fabric be pressed at low temperatures, would indicate that pillows stuffed with shredded dacron should not be exposed to the high

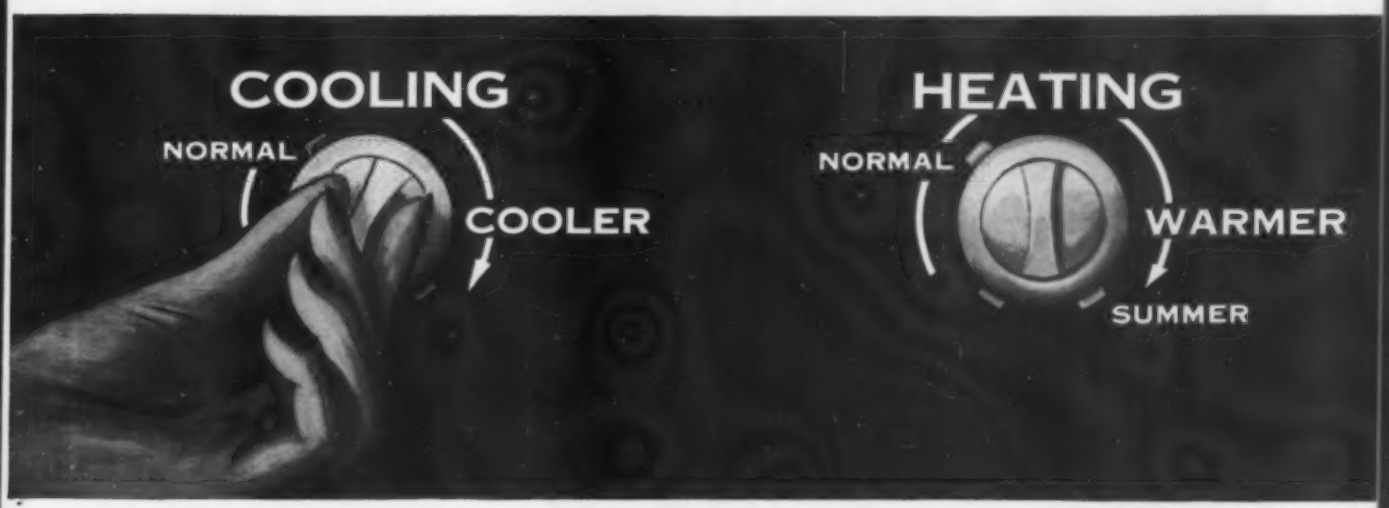
[10]Antiseptics, Disinfectants, Fungicides, and Chemical and Physical Sterilization. ed. G. F. Reddish. 2d ed. Philadelphia: Lea & Febiger, 1957.

[11]Perkins. Op. Cit.

[12]Giedt, W. B.: Personal communication. Jan. 7, 1959.



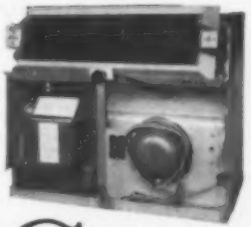
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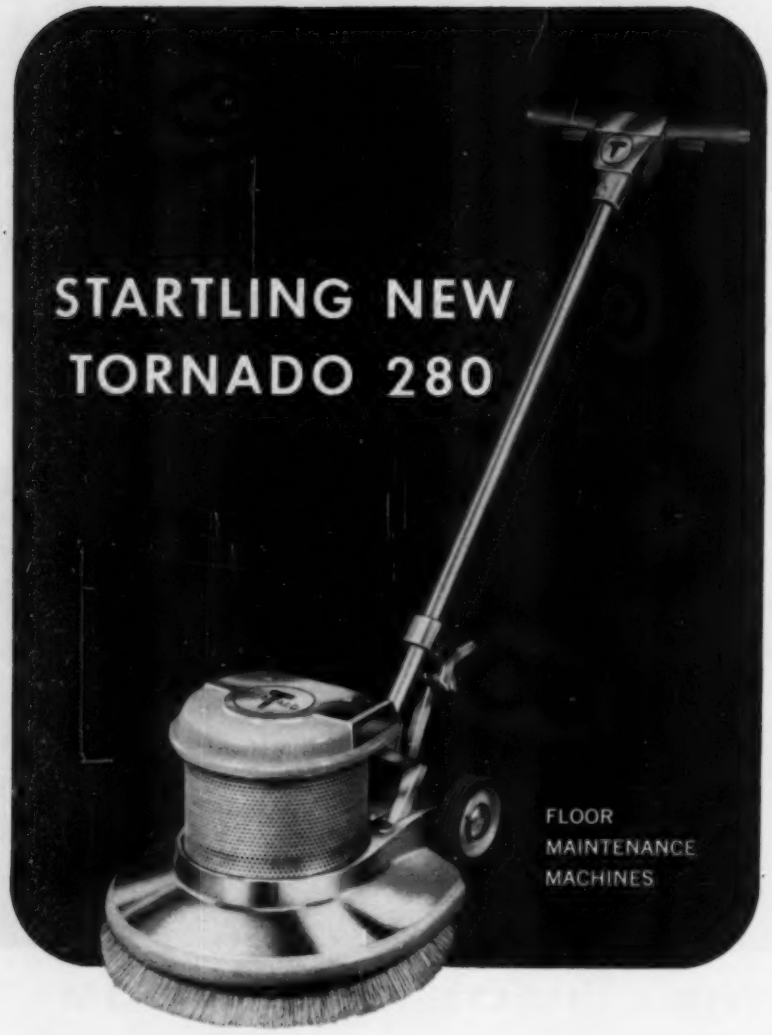
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temperatures required for disinfection for the necessary length of time.

Ultraviolet Radiation. Since ultraviolet radiation may destroy bacteria, viruses and fungi; since exposure to such radiation generally has no effect on materials; and since putting contaminated objects outside to be exposed to the air and the ultraviolet radiation of the sun is a procedure which has long been used, this method deserves consideration.

No reports of the successful use of ultraviolet radiation to disinfect blankets, pillows or similar materials have been found in the literature. The reason for this is indicated by Schmeister, who says: "Because U-V will not penetrate most substances, . . . fabrics, for example, cannot be sterilized by this radiation."[12]

Formaldehyde. A gas which has been used for many years for disinfection is formaldehyde. According to Phillips, when formaldehyde is used at room temperatures and with an elevated humidity, complete sterilization is obtained after one to 12 hours of exposure, depending on the concentration of bacteria and formaldehyde.[14] He goes on to say, however, that ". . . . it is difficult to sterilize throughout porous materials." This occurs, he explains, because, ". . . gaseous sterilization with formaldehyde is somewhat of a misnomer, since introduction of formaldehyde gas into a closed space serves mainly as a mechanism for distributing either solid formaldehyde polymers or moisture films in which formaldehyde is dissolved over all available surfaces. . . ." Once this polymerized formaldehyde is absorbed, it is difficult to remove. Phillips points out that prolonged airing, up to several days, is often required unless this process is accelerated by heat or efforts are made to neutralize the residual formaldehyde. The efforts to do the latter, with ammonia gas, are not always successful.

Blowers, Potter and Wallace expressed the view that, although formaldehyde has been used for disinfection, ". . . there has always been some uncertainty about its efficacy."[15]

From these comments it would appear that formaldehyde is not a suitable agent for the routine disinfection of blankets and pillows. ■

[12]Antiseptics, Disinfectants, Fungicides, and Chemical and Physical Sterilization. Op. Cit.
[14]Ibid.
[15]Blowers, R.; Potter, J., and Wallace, K. R.: Clean Beds. Lancet 1:629 (March 23) 1957.



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Doctors Attack Overutilization Through Review Board

(*Continued From Page* 102)

or foe, a professor or a recent resident.

During the meeting the co-chairmen supply information but take no active part in the decision of the board. Now they notify the Blue Cross business office that the review board has decided:

1. This particular hospitalization is not in accord with the agreement between the subscriber and Blue Cross and therefore Blue Cross should not pay the bill. The specific infraction of the terms of the contract is noted.

2. This particular hospitalization is in full accord with agreement and should be paid.

3. The records are incomplete or confusing. The attending doctor should be asked for additional information before a decision can be reached.

4. The bill should be paid but the attending physician should be apprised of delays or overuse of facilities that tend to increase the cost of hospital care.

In nearly every case a letter is written to the involved attending physician telling him that the case history was examined during the review of a group of cases from his hospital. He is told that the letter is sent to him for his information and that no criticism is necessarily implied regarding his treatment of the patient. A Blue Cross agreement is sent him, with the disputed terms marked in red ink. He is invited, if he feels that the hospital records are inaccurate or incomplete, to write to the board and supply further pertinent information. All correspondence is written and signed by the two co-chairmen. The complete list of review board members is printed on the stationery letterhead.

Our letters have gone to a great variety of doctors. Nationally known surgeons, chiefs of staff, and members of our own board have received letters. An occasional doctor is furious and takes the letter as a personal affront to his honor and integrity. Usually the doctor becomes embarrassed when he goes to the record room and looks at the questioned chart; then he writes to us, giving information that should have been part of the record. Upon receipt of such letter, the case is given to a second group of our board and the additional information is read from his letter. The decision of the second group is relayed to the doctor; occasionally the first decision is reversed and the doctor is told that the board will recommend payment of the bill as soon as he makes the additional information (or a copy of his letter to us) a part of the official hospital record.

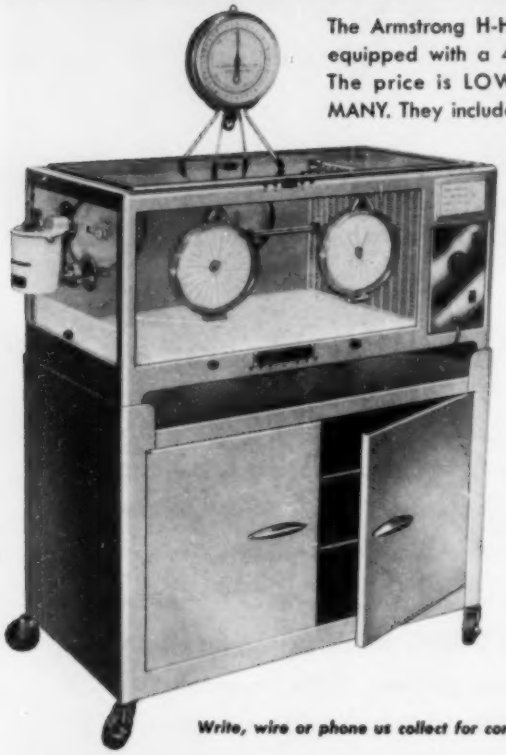
Several doctors have insisted that they be permitted to appear personally before the board to defend their honor and ethics. Since we have never impugned the honor or ethics of any doctor in our deliberation or correspondence, we steadfastly refuse to permit such personal appearances. The co-chairmen take the brunt of all this occasional unpleasantness – they have lived full and productive lives, are looking for no favors or advancement, knew that this would be a part of the duties that someone had to assume, and shrug it off.

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at University of Maryland Hospital



this Silent Glow Destructor completely destroys highly contaminated medical waste and meets rigid demands for no-smoke, no-odor, no fly-ash operation

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Because of unique positive pressure, high temperature operation within multiple chamber construction, this unit effectively performs the most difficult disposal tasks safely, sanitarily. Charge material is reduced to a fine white ash that's totally free of organic residue . . . that can easily be removed with a vacuum cleaner. Wet portions of the load are most efficiently handled without excessive fuel consumption because the unit's design permits recirculation of gases, returning a portion of heat from the combustion chamber to the charge chamber to assist destruction of the wet material.

Additionally, this unit is so designed that it uses the Hospital's existing chimney and can be moved to another location should future plans make it necessary. Write for complete information . . . for specific recommendations, briefly describe your disposal problem.

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by Commissioner Smith, namely "to develop and carry out methods and plans to reduce unnecessary utilization of hospital service."

We have studied and recorded factual information from hospital charts selected because of definite criteria. The charts were not chosen at random, nor by numerical sorting; consequently no statistical "percentages" will be forthcoming. We have used as our compass Commissioner Francis R. Smith's words: "Unnecessary utilization of hospital service can be substantially reduced by proper action and cooperation of all interested parties. Any suggestion that we can't do anything about it because we don't know to what extent the abuses exist should be summarily rejected."

In the study of thousands of charts we have found only one instance of frank dishonesty (the discovery of which was our first big milestone; it was corrected promptly to everyone's satisfaction).

Sixty-five per cent of our local citizenry has contracted with Blue Cross for prepaid hospital care. A contract binds two parties in the fulfillment of certain duties. The present contract which ensures this care is a good one; it has been drawn and is being administered under the watchful eye of the insurance commissioner.

The solvency of the entire plan is dependent upon proper and effective utilization of hospital beds and services. The physician decides when patients are to be admitted to the hospital; he orders laboratory procedures, drugs and treatments; he decides when the patient should be discharged. Many physicians and most subscribers are not aware of contract restrictions, hence unintentional abrogation is widespread.

The cost of hospital service is rising alarmingly; we hope that our board of practicing physicians can induce their friends and associates to use highly expensive hospital services wisely so that good hospital care becomes available to all at a reasonable price. For example, a one-half day reduction in the average hospital stay would save the Philadelphia plan more than $3 million a year. The only one to profit by what Blue Cross saves is the man-on-the-street subscriber-patient. We hope we can use our efforts in getting doctors and hospitals and Blue Cross plans to solve their mutual problems without political interference. ■



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A new wing at Doctors Hospital, Michigan City, Indiana, promises to serve as a heating-cooling guide for hospitals when versatility is a must.

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(*Continued From Page* 111)

The crash of glass and the cry of fire brought people in adjacent offices to the scene and two other calls on direct lines were placed to the Columbus fire department. Employes grabbed available extinguishers and tried to contain the blaze at the door of the room to prevent spreading. A raging inferno, caused by a combination of benzene-based adhesive sticking to the varnished and painted walls, developed in less than a minute.

Because of the pipe work between the floors the flash fire rapidly spread upward. The succession of events within the next two minutes was so swift that they are difficult to relate.

Fire trucks arrived almost immediately and fire officials subsequently placed a second and then a third alarm. Employes moved from station to station quietly and calmly informing nurses of the fire. Fire doors on each floor were immediately closed, thus confining smoke and damage to the older center portion of the hospital. Nurses and aides moved from room to room closing doors and placing blankets under the doors to keep smoke from reaching the patients.

Surgery personnel noticed the congregation of fire equipment on the street and efficiently completed all cases without any hysteria. Offices were abandoned in the fire area (center portion of the hospital where the fire occurred is primarily administrative offices). Two members of the fire committee quickly organized evacuation teams and moved 18 children from the pediatrics area to a safer location in the new wing where an emergency nursing station was established. Fans were dispatched from a storeroom to exhaust smoke from hallways in the patient areas.

Two telephone company employes, who were in the building to prepare a loud-speaker system for the Sunday dedication, immediately informed their company that the switchboard was cut off, and within an hour communications had been restored temporarily; within the day complete operation was restored.

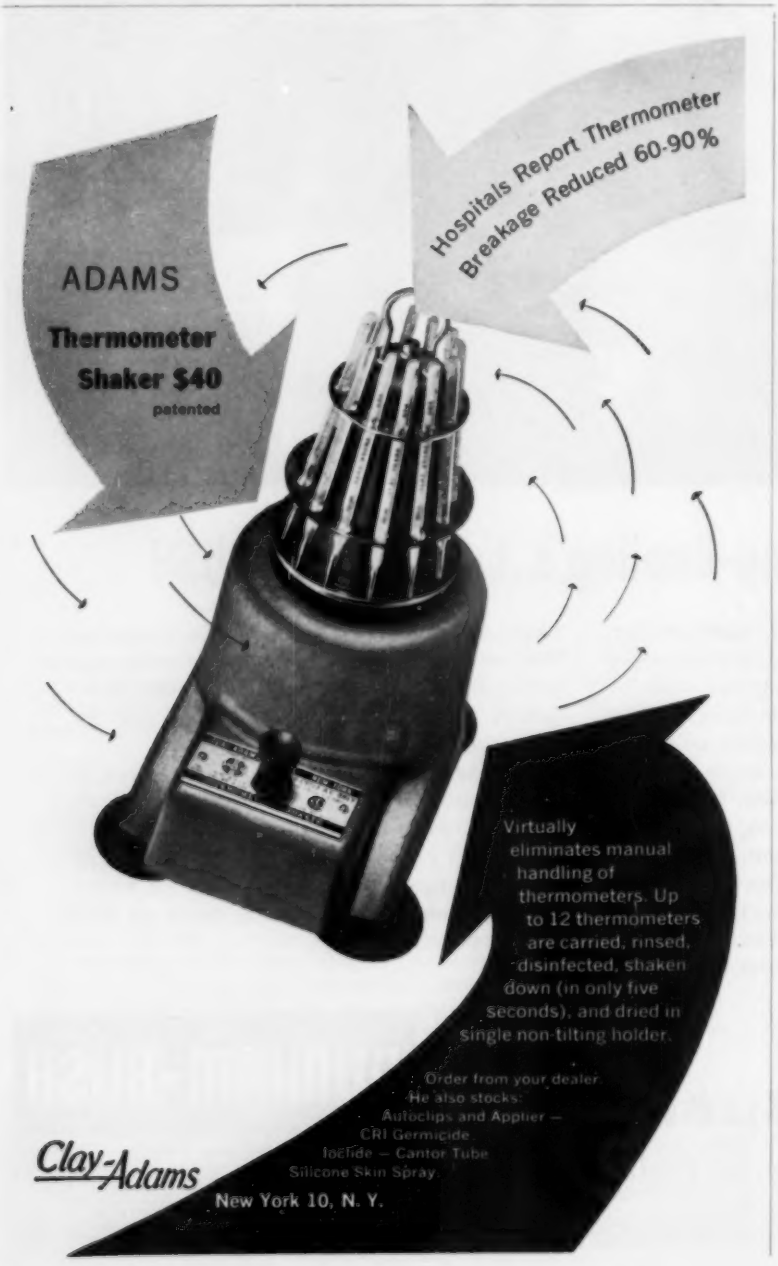
Within 27 minutes the fire was under control, but in this brief period some $75,000 damage was caused. No patients were in danger at any time. The plans and practice were there and, when the chips were down, all performed their duties according to plan. Only the four workers were injured in their attempts to control the blaze.

A first step following the "all-clear" was a brief press conference in the smoky hospital lobby. These few minutes paid dividends many times over in developing community good will and complimentary press coverage.

The aftermath or reorganization period was probably the most trying. Before the smoke had cleared, temporary offices were planned, reconstruction activities were under way, air-purification teams were called in, special cleaning procedures were placed in effect, and a thousand and one other details were attended to.

By nightfall, everything was in order. It had truly been a suspenseful day — a day which did honor to the personnel — but not quite as we had planned.

The fire committee learned many important lessons from the near-disaster. Most important was the doctrine that hospital employes can be counted on to carry out their instructions if they are prepared and know their duties. ■



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Electronics Is Changing Structure of Hospitals

(*Continued From Page 87*)

the medical profession, but Dr. MacGuire sees nothing unethical or smacking of commerce in the idea. As an example of what has already been done along this line, he points to such an eminently respectable organization as the Palo Alto Clinic.

The costs of rendering care and determination of charges to subscribers will be a subject for investigation by authorities on hospital and medical economics in collaboration with all the other research groups at the Atomedic center.

As has been pointed out, the founders of Atomedics are convinced that the hospital-medical problem is so big and has so many ramifications that it must be tackled all at one time from all angles by all the disciplines involved.

"Everyone agrees that we've got to start somewhere," Dr. MacGuire points out, "and it seems to us that the best place to start is to bring the doctors, physicists, biologists, pathologists, anthropologists, computer people, industrial engineers, sociologists — and all the others here to Montgomery to a research center where they will have a chance to live and work together and understand one another as they never can as long as each group continues to work separately."

Why Montgomery? Its primary advantage as a research center lies in the very fact that it does not already have a medical center and hence the research workers would not be inhibited by the preconceptions and prejudices of an established organization.

It does have the facilities of Air University and of Auburn University near by, which are already working with the Atomedics group on various projects. Prof. Percy South of the Research Studies Institute at Air University is a member of the Atomedics board of directors, and the Veterinary School at Auburn has undertaken a study of the possibilities of developing physiological transducers capable of being worn comfortably at all times. These will telemeter physiological data directly to a multichannel tape recorder which can be fed into a computer for analysis.

Furthermore, a sympathetic legislature has enacted a bill that will make it possible for Atomedics to experiment with all kinds of building materials, without being hampered by restrictive building codes, permits and fees.

In the course of his long, carefully detailed explanation of Atomedics to a reporter, Dr. MacGuire would pause from time to time to inquire anxiously: "Does all this seem too far-fetched — too Blue Sky?" To a backward earthling, who views the automatic elevator with suspicion, it did seem a little hard to comprehend. But Dr. MacGuire's intellectual equals have no such qualms. To them, it is as much as anything a matter of logistics: of rounding up all the brains and skill and imagination that have already created computers and transducers, plastics and disposables — and put them to work for the benefit of human health.

Dr. MacGuire, who regards the Atomedic project not only as a significant instrument for the health of mankind, but as a crusade for world peace, has no doubts at all of its ultimate success. To the reporter's final question: "Do you expect to live to see all this, Doctor?" he shot back: "I sure do." ■

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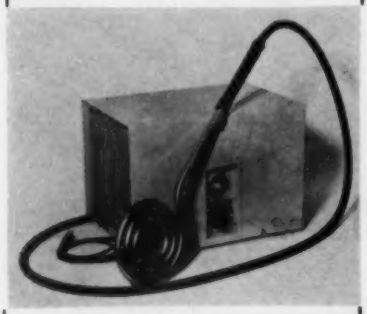
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Arthur Flemming Stays on the Firing Line

(*Continued From Page* 94)

bill, admitting freely that it didn't have White House approval and probably wouldn't get it. The bill would cost too much. Three weeks later the Secretary was able to introduce his own bill.

For a man who doesn't like controversy, Flemming is leading a strange life. The cranberry episode is just one of the many wrangles he has found himself in. It received more publicity, but is no more important than several others; nor was it more bitterly fought.

Because Flemming wasn't afraid of possible libel suits, the federal government for the first time is publishing lists of schools it regards as diploma mills.

Again discarding caution, he issued a militant statement defending the fluoridation of water supplies to reduce dental caries and attacking the fringe of scientists and others who oppose the process.

He is trying to get Budget Bureau approval for legislation that will empower the U.S. to put strict controls on amphetamines and barbiturates.

On the question of using minute amounts of carcinogens in color additives to foods, drugs and cosmetics, the Secretary is doggedly holding off these three big and influential industries. He maintains, with support from the National Cancer Institute, that there is no way to set "safe" tolerances for carcinogens in the human diet – if the product can be made to produce cancer in animals, it's out.

He is raising beds of enemies in various parts of the country by invoking a new federal law and making communities and industries get the pollution out of waterways.

Moving into an area that the Federal Trade Commission might be neglecting, Flemming denounced false advertising of dentifrices, again risking libel suits.

Flemming has had superb press relations – possibly too good.

His two predecessors as H.E.W. Secretary, Oveta Culp Hobby and Marion B. Folsom, appeared fearful of the press, working on the theory that no publicity is better than bad publicity.

Flemming started regular news conferences, every two weeks or oftener when warranted. He brings so many of his own experts into the room that often reporters must take notes standing.

Generally the press conferences touch on half a dozen to a score of subjects. Well-done press releases are prepared in advance on agenda items, but questions can cover any subject involving all of the agencies and divisions that report to Flemming.

The Secretary attempts to answer all the questions he can himself, but if pressed beyond his depth he calls on the experts. The net result is that at least twice as much information comes out of the department now as at any time in the past.

Shortly after taking over, Flemming adopted a system of close contact with the top men at H.E.W., while allowing most of them all the freedom they need to run their operations. He also makes routine inquiries as to what material is suitable for announcement, and sets dates when he expects the material to be ready for release.

At one point last year, this system of get-out-all-the-news-you-can-and-as fast-as-you-can might have been working too well. At least Flemming and his press men were accused of giving H.E.W. and N.I.H. credit for research developments that actually were not being accomplished by the government or on government money, but were merely discoveries that the National Institutes of Health happened to be aware of and reported.

This fracas ended in a draw. There was a flurry of stories criticizing Flemming and his press people, followed by a detailed explanation by Flemming about how information is gathered and released. He didn't succeed in clearing himself entirely, but now a little more care is used in preparing press releases and the criticism has ceased.

Secretary Flemming's skill in personal public relations is the way he has moved in and out of Washington jobs during Democratic and Republican administrations, like a bellhop through a swinging door. Except he is no bellhop to anyone, even though he does his best work politely and unobtrusively.

The explanation is that he is in demand. He wears his Republicanism like a badge, but it is the kind of Republicanism that was respected by two Democratic presidents, Roosevelt and Truman, although both shot from the hip at most Republicans. ■



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The Modern Hospital News Digest

How To Tell the Presidents Without a Score Card

Among the essential activities of convention delegates is the election of new officers. Here is a round-up of presidents and presidents-elect named by regional associations at the spring meetings:

Association of Western Hospitals

PRESIDENT: JOHN ZENGER, administrator, Utah Valley Hospital, Provo.
PRESIDENT-ELECT: JOSEPH L. ZEM, administrator, St. Luke's Hospital, San Francisco.

Carolinas-Virginias Hospital Conference

PRESIDENT: JOSEPH E. BARNES, administrator, Rex Hospital, Raleigh, N.C.
PRESIDENT-ELECT: ESTHER TOUCHBERRY, administrator, Marion Sims Memorial Hospital, Lancaster, S.C.

Middle Atlantic Hospital Assembly

PRESIDENT: DAVID V. CARTER, administrator, Fitkin Memorial Hospital, Neptune, N.J.
PRESIDENT-ELECT (vice president 1960-61): CARLTON B. SHANNON, administrator, House of the Good Samaritan, Watertown, N.Y.

Mid-West Hospital Association

PRESIDENT: C. E. COPELAND, administrator, Missouri Baptist Hospital, St. Louis.
PRESIDENT-ELECT: CARLOS SMITH, administrator, Community Hospital, Helena, Ark.

Southeastern Hospital Conference

PRESIDENT: GENE KIDD, administrator, Baptist Hospital, Nashville, Tenn.
PRESIDENT-ELECT: E. E. CAVALERI Jr., administrator, Crippled Children's Clinic, Birmingham, Ala.

Tri-State Hospital Assembly

PRESIDENT: RALPH HAAS, administrator, Culver Union Hospital, Crawfordsville, Ind.
(New officers to be elected at the annual meeting in July)

Upper Midwest Hospital Association

PRESIDENT: J. E. ROBINSON, superintendent, Children's Hospital, Winnipeg, Manit.
PRESIDENT-ELECT: JACK L. ROGERS, administrator, Sioux Falls, S.D.

For other convention reports, see pages 112, 113, and 174

Outlook Good for Hospitals, Economist Tells Upper Midwest Meeting

MINNEAPOLIS. — **Hospitals should go ahead with expansion plans because the business outlook for the next seven to eight years is good, Arthur R. Upgren, Macalester College economist, said before a large general session audience at the Upper Midwest Hospital Conference in Minneapolis, May 11.**

But one of the big tasks of hospital administrators will be to convince the public that rising costs of hospital services are justified because of improved quality, Mr. Upgren added in his talk on "Inflation — High, Wide and Handsome."

Speaking at the opening general session on "Administrative Leadership — Skills and Technics," James Hamilton, director of the University of Minnesota's course in hospital administration, pointed out that the successful leader is aware of forces governing his behavior at any given time and then acts accordingly.

Combinations of leadership qualifications discussed by Mr. Hamilton were: (1) a sense of awareness of the immediate situation plus definite goals for a long-range future; (2) possession of an "innate liking for change plus a strong desire to get things done"; (3) ability to "allay the anxieties of the group plus an interest to arouse the group," and (4) ability to symbolize the values of the group while putting forward his individual character.

The public probably will increase its spending for hospital care, "but they'll want to spend it well," said Walter J. McNerney, who directed a study of how hospitals are used in Michigan. "Pressure groups more and more will demand better accounting of hospital use," he added.

Mr. McNerney, who is director of Michigan's program of hospital administration, found in his study that in 19 per cent of the cases, the length of hospital stay was either too long or too short based on standards determined by a panel of doctors.

"Overstay," he said, was three times as great "when someone else paid the bill."



IS THERE TOO MUCH TALK ABOUT RESISTANT STAPH AND TOO LITTLE ACTION IN PREVENTING INFECTION?



Medical and hospital trade literature, the last few years, has been filled with articles and advertisements about resistant Staph. The problem has been serious. But we feel that resistant Staph is not the basic problem. It is the danger to patients from **all kinds** of infection. A workable patient-safety program is not an easy one to maintain.

A giant step toward the solution of this infection problem can be taken, we feel, by recreating the old-fashioned attitudes toward cleanliness in **all** hospital personnel in **every** department.

These old-fashioned attitudes, combined with modern, efficient, aseptic products, can help you prevent cross infection. Write for a detailed explanation of our Patient-Safety Program. The pamphlet, "A Suggested Plan of Infection Control in Hospitals," is free and full of valuable information.

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Frank Groner Reviews Goals for Hospitals at Association of Western Hospitals Meeting

LOS ANGELES. — The peripatetic president-elect of the American Hospital Association, Frank S. Groner, was the airlines' best friend last month. In a tight schedule that called for stops at four other regional meetings, Mr. Groner caught his breath at the Association of Western Hospitals long enough to make the following points:

Hospital-employe relations are getting better all the time, but much more needs to be done.

Philosophically, every group of patients should reimburse the hospital fully for hospital expenses.

The trend toward full government payment for the care of the indigent must be pursued until government patients no longer are a financial drain on hospitals.

Funds for replacement of the hospital plant must be part of hospital budgets.

Hospitals must have the foresight to survey the need for more beds voluntarily at the local, state or regional level or they will probably be forced into doing it by regulatory agencies.

The cost of educating hospital employes should not be passed on to patients but should be shared by the entire community.

The next 10 years will see more changes in hospital design and operation than any like period in history, prophesied James A. Hamilton, director of the course in hospital administration at the University of Minnesota School of Public Health.

Speaking before the opening session of the convention, he said:

"One major change in the hospital of the future will be in the actual design of the facility. In place of the traditional structure with its long corridors which send nurses and doctors walking miles a day, the new building will be circular in design with the patients' rooms on the outside rim of the wheel and the nursing stations in the central core. Each room in the hospital will be but a few steps from the nursing station.

"This new design is already proving its worth at Valley Presbyterian Hospital, Van Nuys, Calif., (see p. 103 and The MODERN HOSPITAL, March 1957, p. 74) and a few other progressive hospitals throughout the nation," he added.

The demand for more, and more complicated, hospital services was seen as the greatest challenge to hospitals. Donald S. Showman, administrator of Kennedy Deaconess Hospital, Havre, Mont., reminded the delegates of some of the problems.

"From an economic standpoint, hospitals are becoming less different each year. The altruistic employe whose compensation is primarily an opportunity of service is gradually disappearing and the hospitals are endeavoring to bring salaries to a level in keeping with the wages paid by other industry," he said.

Officers elected included: vice presidents, Raymond Farwell, Swedish Hospital, Seattle; Sister Agnes of Sacred Heart, St. Joseph's Hospital, Burbank, Calif., and Paul R. Hoff, Bannock Memorial Hospital, Pocatello, Idaho. Treasurer is Clifton H. Linville, Fresno Community Hospital, Fresno, Calif.



Western officers (l. to r.): president-elect, Joseph L. Zem; treasurer, Clifton H. Linville; president, John Zenger; vice presidents, Paul R. Hoff and Sister Agnes of the Sacred Heart; past president, Wesley G. Lamar.

Tri-State Delegates Hear Why Care of Aged Costs What It Does

CHICAGO. — Delegates to the Tri-State Hospital Assembly here May 2 to 4 (about 8400 of them) seemed to be more interested in looking than listening. Spot-checks of meetings and exhibits during the three-day session showed that exhibitors' booths were crowded a good part of the time, while in many of the meeting rooms, speakers, panelists and program chairmen were left sadly talking to one another and a sea of empty chairs.

The impossibility of predicting which subjects would attract large audiences, mentioned by one Tri-State official, was borne out by the fact that even sessions devoted to the same general subject drew widely disparate audiences, both as to size and responsiveness.

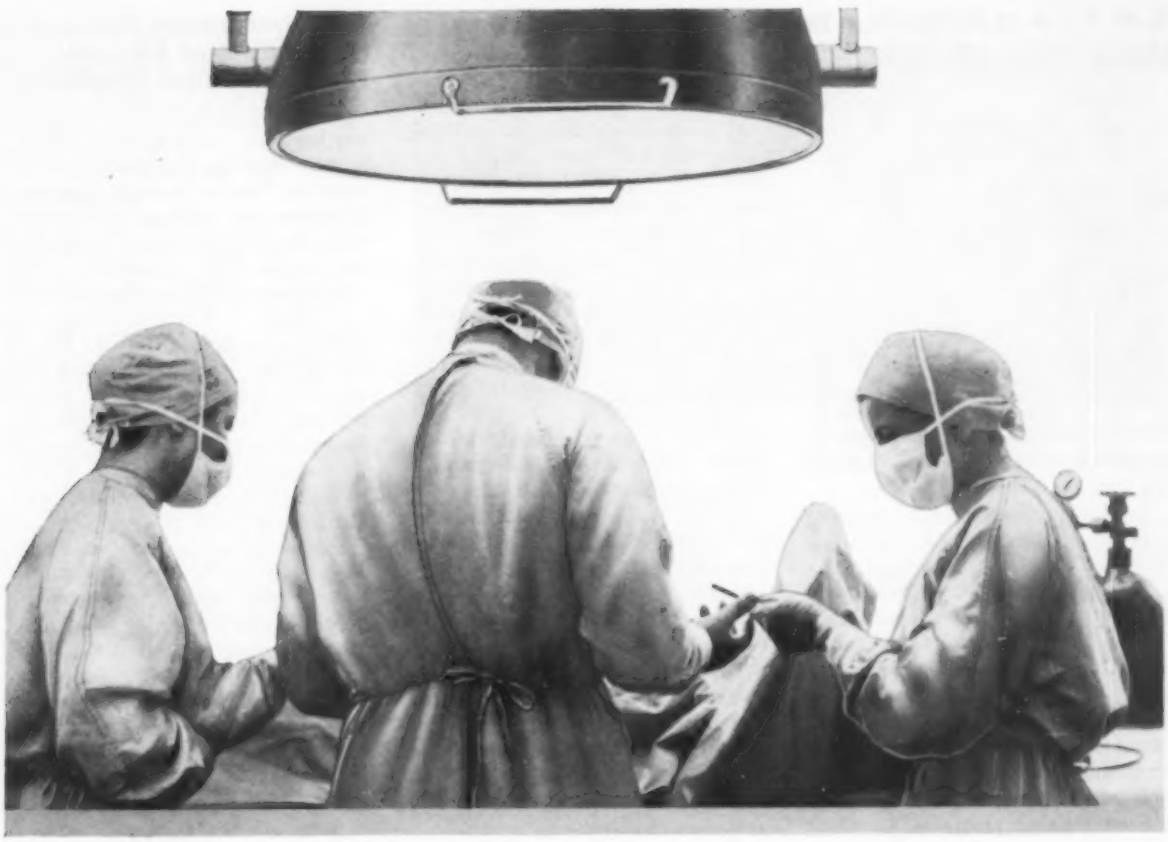
Sessions on the health care of the aging were a case in point. At the federal hospital meeting devoted to this problem on Tuesday afternoon, the speakers' voices bounced hollowly back to a small group huddled in the last three rows of the Palmer House's grand ballroom. On Wednesday afternoon, when delegates as a rule are departing in droves, a large and interested group sat still for two hours while Prof. Wilbur J. Cohen of the University of Michigan explained where the money to provide adequate health care of the growing aged population will have to come from. This, in Prof. Cohen's view, will be the federal government, preferably through the social security mechanism.

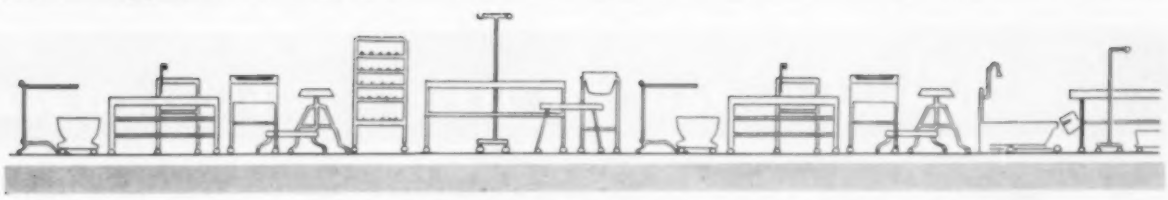
At the outset of his talk, Prof. Cohen explained that he was not "whooping it up for some developments that may be unfortunate," but that he felt it is his duty as a man trained in economics to point out some unpalatable economic facts that can't be "brushed under the rug."

Among the facts which he believes point to social security as the only feasible means of paying the costs of health care of the aged are:

1. Not only is the aging population increasing all the time, the "aged are getting older all the time." This is important, he explained, because the older people get, and the more of

(*Continued on Page* 184)





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A.M.A., A.H.A. To Get Tough With Hospitals Using Uncertified Foreign Medical Graduates

CHICAGO. — Hospitals that use uncertified foreign graduates in their internship and residency programs face stern measures by the American Medical Association and the American Hospital Association.

Under the new A.M.A. policy to go into effect July 1, a hospital that uses foreign trained interns and residents who do not meet the new requirements can lose approval of its training program. **According to the A.M.A. Council on Medical Education and Hospitals, foreign graduates must meet at least one of the following four requirements:**

1. Have a state license to practice.
2. Be in their last six months of training.
3. Hold a standard or temporary certificate from the Educational Council for Foreign Medical Graduates.
4. Have a contingent appointment based on their having been accepted for the September 1960 certifying examination.

Although the A.M.A. ruling affects only about 1400 hospitals with approved training programs, its effect is reinforced by the American Hospital Association's decision to cease listing hospitals which employ uncertified foreign medical graduates in patient care situations.

The A.H.A. listing program is not intended to be a measure of quality of care, Dr. Edwin L. Crosby, A.H.A. director, explained. However, listing is a prerequisite for accreditation; thus if a hospital loses its listing, it automatically loses its accreditation.

Loss of listing can also have economic effects, as some insurance companies will not pay for patients treated in an unlisted hospital.

On the March 16 examination only 55.5 per cent of the foreign trained graduates qualified for certification, according to the E.C.F.M.G. report. Another 21.7 per cent qualified for two-year temporary certificates.

Dr. Dean F. Smiley, the council's executive director, said it was the examination committee's opinion that apparently the better qualified physicians had taken tests earlier. The council has conducted them twice a year since March 1958.

Yale Symposium Advised Hospitals Must Educate Foreign Medical Graduates

NEW HAVEN, CONN.—Community hospitals must take more seriously their educational responsibilities in accepting foreign medical graduates as interns and residents and not use them simply as necessary "hands and feet" on the staff, a symposium at the Yale School of Medicine here was told.

Dr. John C. Leonard, director of medical education at Hartford Hospital, Hartford, Conn., emphasized that the many irritating problems related to foreign graduates on American hospital staffs are linked in most cases to the hospitals' neglect of adequate educational programs not only for the staff but for practicing physicians.

Failure to assume educational responsibility has brought on much ill feeling and unfortunate publicity, *Scope Weekly* reported.

Dr. Leonard, who is chairman of the American Medical Association committee on postgraduate education, also warned hospital representatives that foreign graduates are now receiving better advice on American institutions and are no longer rushing to accept just any hospital appointment.

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The Philadelphia plant of SKF Industries, Inc. — leading manufacturer of ball and roller bearings, had a particularly tough cleaning problem — BEFORE using the Clarke-A-matic self-propelled floor maintainer. Seven men with hand equipment scrubbed 13,500 sq. ft. of production floor area nightly in order to cover the entire factory once every two weeks. Besides the usual dirt, the floor was liberally splattered with oil, coolant and grease. And these seven men, with their hand cleaning equipment, did a barely adequate job.

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Columbia Lists Residents in Hospital Administration

NEW YORK. — Columbia University School of Public Health and Administrative Medicine has announced the following residencies in hospital administration:

John E. Baer to Sinai Hospital, Detroit; Benita Cirulis to Herrick Memorial Hospital, Berkeley, Calif.; Dr. Oscar L. Criollos to Jackson Memorial Hospital, Miami; Thomas R. Crowdis Jr. to Massachusetts Memorial Hospitals, Boston; Warren C. Falberg to Barnert Memorial Hospital, Paterson, N.J.

Sherwin Z. Goodblatt to Maimonides Hospital, Brooklyn, N.Y.; Lewis Lesser to Beth-El Hospital, Brooklyn, N.Y.; Arthur Lucks to Mount Sinai Hospital, New York; Monroe O. Mitchel to Montefiore Hospital, New York; Claude A. Moldaver to Jefferson Medical College and Medical Center, Philadelphia; Robert W. Murphy to U.S. Public Health Service Hospital, Staten Island, N.Y.

Frederic C. Nicewicz to Griffin Hospital, Derby, Conn.; Alton W. Noyes to Ellis Hospital, Schenectady, N.Y.; Henry Olshin to Lebanon Hospital, New York; Leo A. Petit to Danbury Hospital, Danbury, Conn.; Felix M. Pilla to Hackensack Hospital, Hackensack, N.J.; Alfred F. Popoli to Mountainside Hospital, Montclair, N.J.

Robert J. Robertson to Mount Auburn Hospital, Cambridge, Mass.; Paul Selbst to Hospital for Joint Diseases, New York; Michael E. Shalhoub to Veterans Administration Hospital, Brooklyn, N.Y.; Steven Sieverts to Hunterdon Medical Center, Flemington, N.J., and Donald P. Teece to Community Hospital at Glen Cove, Glen Cove, N.Y.

COLUMBIA UNIVERSITY RESIDENTS



New York Hospital Drops Bellevue—in Name Only

NEW YORK. — Two New York medical institutions have new names. New York University-Bellevue Medical Center will be known as New York University Medical Center, according to Dr. George E. Armstrong, director of the medical center. The word Bellevue was eliminated to emphasize the Center's role as an "integral part" of N.Y.U., Dr. Armstrong explained.

N.Y.U. College of Medicine will be known as New York University School of Medicine.

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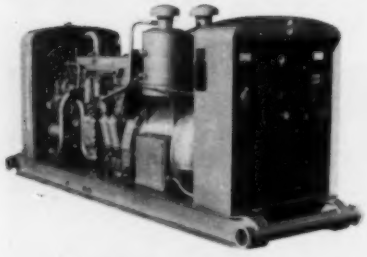


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Middle Atlantic States Elect New Officers

ATLANTIC CITY. — New officers elected by the three state associations of the Middle Atlantic Assembly are:

New Jersey: president, Robert E. Heinlein, Overlook Hospital, Summit; president-elect, Benjamin W. Wright, Orange Memorial Hospital, Orange; vice president, Nelson O. Lindley, Somerset Hospital, Somerville, and treasurer, Warren G. Rainier, Mountainside Hospital, Montclair.

New York: president, Alex E. Norton, New Rochelle Hospital, New Rochelle; first vice president, Dr. Bernard A. Watson, Clifton Springs Sanatarium and Clinic, Clifton Springs; second vice president, Alvin J. Binkert, Presbyterian Hospital, New York; secretary, Howard R. Taylor, Niagara Falls Memorial Hospital, Niagara Falls, and treasurer, Dr. Thomas Hale Jr., Albany Hospital, Albany.

Pennsylvania: president, Mable A. Barron, Ellwood City Hospital, Ellwood City; president-elect and first vice president, T. K. Leinback, Community General Hospital, Reading; second vice president, Sister Mary John, New Castle Hospital, New Castle, and treasurer, Joseph W. Bishop, Hahnemann Hospital, Scranton.

Committee Formed To Help in Health Facility Planning

WASHINGTON, D.C. — George Bugbee, president of the Health Information Foundation, New York, has been named to head a new health planning committee.

Announcement of the 15 member *ad hoc* committee was made jointly by the U.S. Public Health Service and the American Hospital Association, co-sponsoring organizations.

The committee, composed of authorities in the hospital and health facility field, will develop principles for communitywide health facility planning, according to Dr. Edwin L. Crosby, director of the A.H.A.

Other major objectives set for the committee include the development of principles to be followed in the formation of area planning groups and steps which should be taken to assure the acceptance of a planning organization as the authoritative central hospital planning agency of the community, he explained.

Northwestern Alumni Launch Fund Campaign To Aid New Curriculum

CHICAGO. — The Alumni Association of the Graduate Program in Hospital Administration of Northwestern University's school of business announced plans to launch a two-year fund raising campaign for $25,000. The announcement was made at a meeting during the Tri-State Hospital Assembly here last month.

The funds will be used to help to finance research and development of an experimental curriculum in which hospital administration would be offered as a major field in the established Master of Business program of the Graduate School of Business Administration, according to Carl Nusbaum, president of the association.

Mr. Nusbaum, who was recently appointed administrator of Gottlieb Memorial Hospital, Chicago, stated that alumni and friends wish to show their deep interest in continuation of education in hospital administration at Northwestern University by this financial aid. He added that considerable expense would be involved in a change from the specialized program and degree, previously announced as ending in June 1961, to a new pattern leading to a M.B.A. degree with a major in hospital administration.

Laura Jackson, assistant director of the program, spoke of the progress being made on the new program. She said that prospects for the post of director are being interviewed.

"Actually, appointment of a director is all that is holding up the plans. It is all that prompted the decision to take no students next fall," she told the group.

N.C. Hospital and Panama Start Training Program

CHAPEL HILL, N.C. — A training program for hospital department heads from Panama is scheduled to begin at North Carolina Memorial Hospital sometime within the next year, according to Dr. Robert R. Cadmus, director of the hospital, which is affiliated with the University of North Carolina.

The program will be undertaken jointly by the hospital and the Caja de Segure Social of Panama, a Panamanian governmental agency that operates a chain of medical facilities.

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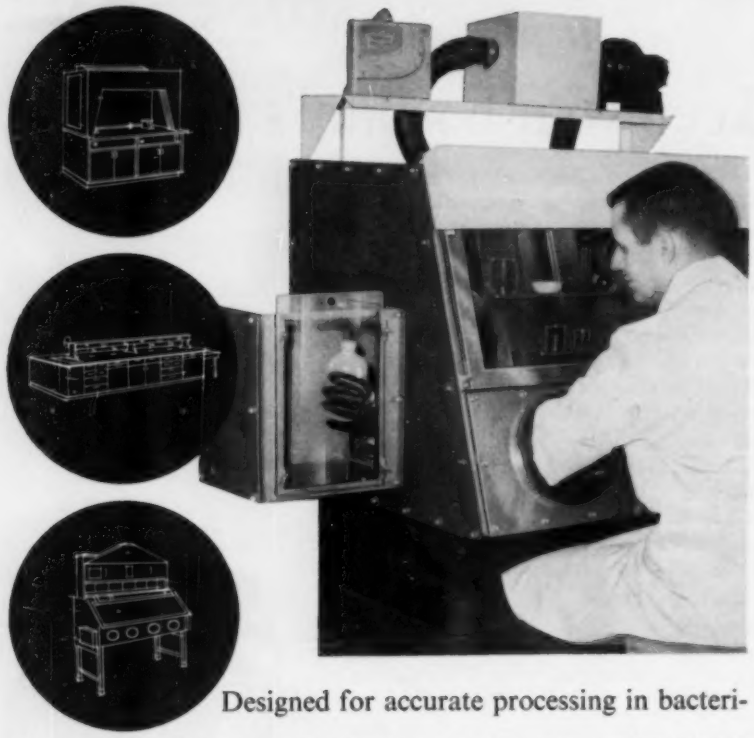
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Carolinas-Virginias Regional Conference

(*Continued From Page* 113)

for our unions, he said, pointing out that no one union has jurisdiction in hospitals, thus opening the field to all of them.

As at other regional hospital meetings, the problem of financing hospital care for the aged was discussed against a daily background of newspaper headlines that described proposals and counter-proposals that were being considered by Congress at the time of the meetings (see page 77). Presenting the American Medical Association view on this subject, Aubrey D. Gates, A.M.A. director of field services, called for more research on the problem, a position that has been fashionable among medical association officials for several years.

Those who felt that it is a little late to rely solely on research for a solution got tacit encouragement from William L. Wilson Jr., administrator of Mary Hitchcock Memorial Hospital, Hanover, N.H. Mr. Wilson, a member of the American Hospital Association committee that is studying this problem, said the voluntary methods of solving it seem to be providing too little too late.

"The practical fact of life," he said, "is that there is a growing body of well informed opinion in Washington that is certain it is no longer a question as to whether the federal government is going to participate in the financing of health care of aged persons.

Organized labor's view of this problem was presented by Miles C. Stanley, president of the West Virginia Labor Federation, A.F.L.-C.I.O.

"Survey after survey," he said, "shows that American citizens over the age of 65 are not getting the medical care they need. This, he said, is "simply because they accept their symptoms instead of risking the expense of having them diagnosed." The passage of this legislation, he said, would mean that hospitals "would be relieved of financial burdens and would be able to pay better wages and salaries. It is not fair that one segment of the population, such as hospital workers, should receive lower wages in order to support another segment, such as the older indigent," Mr. Stanley emphasized.

(*News Continued on Page* 183)



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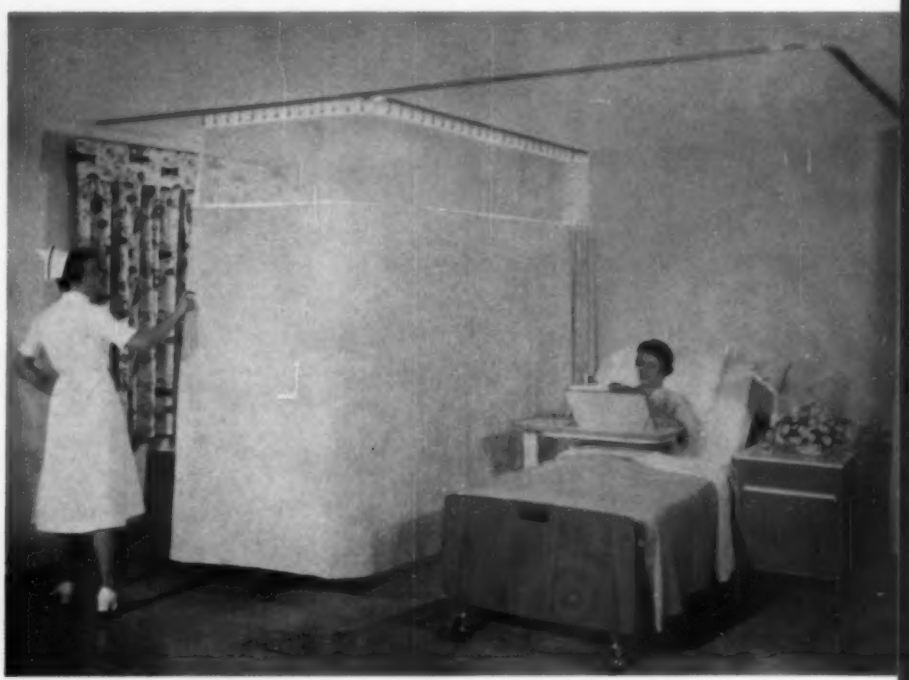
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Patient Doesn't Swallow Drug Nomenclature, Senator Says

(*Continued From Page 88*)

macist select the product: "They have left you to cross the river with the bridge uncompleted," Mr. Miller said of this situation.

Final witnesses for the committee were representatives of the National Pharmaceutical Council, a drug trade association concerned mainly with problems of substitution. Speaking for the Council, Newell Stewart, Ph.D, executive vice president, repeated the objection that "drugs bearing the same generic name are not necessarily therapeutic equivalents," and pointed out that any failure to provide exactly what the physicians prescribed may properly be termed substitution.

"For the pharmacist to impose his judgment upon that of the physician is assuming a responsibility which he is not qualified to assume," Dr. Stewart said.

Commenting on the practice, described by several witnesses, of providing drugs by generic name for charity or welfare patients and by trade name for private patients, Sen. Philip A. Hart (D.-Mich.), who substituted for Subcommittee Chairman Estes Kefauver throughout most of the hearings, declared: "I think we would all agree that this isn't the way we resolve this question, because there really isn't any price tag on safety." ■

Hospitals Misuse Nurses, Institute Speaker Charges

CHICAGO. — Misuse of professional personnel is aggravating the nursing shortage, a national authority has charged.

"We can no longer afford the luxury of wasting the nurses' time on chores not specifically included in the nursing function," said Margaret Griffin Ellsworth, former director of the department of hospital nursing of the National League for Nursing.

She spoke before a statewide institute of the Illinois Hospital Association.

Mrs. Ellsworth criticized the use of nurses for clerical work, errands and housekeeping duties, and suggested that less trained persons be hired for such work, according to the report in the *Chicago Daily News*.

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Tri-State Assembly Delegates Hear Why Care of Aged Costs What It Does

(*Continued From Page* 174)

them there are, the greater are their needs for health care.

2. The life expectancy of women is longer than that of men, which means there will be many more widows — a group whose income, generally, is the least adequate of any in the country.

3. Public assistance is not acceptable to the American public as a means of obtaining needed hospital and medical care. Nor are private charity or dependence on children acceptable. The reluctance of parents to be dependent on their children, and the reluctance of children to pay their parents' medical and hospital bills is "why we have this push toward insurance," Prof. Cohen explained.

4. The social security device has finally been accepted and integrated in the American way of life. People are no longer frightened by the idea of compulsion. They have already accepted compulsory education, compulsory workmen's compensation, and compulsory social security.

5. The American public has a "rising standard of expectations." This has been generally overlooked, Prof. Cohen pointed out, but it is highly significant. The day when a decent standard of food, clothing and shelter was all the general public expected is over, he said. Today, it is assumed that every individual has a right to all the medical care and education he can utilize. "This is what is going to push an inflation in the costs of both education and medical care," the speaker asserted.

To Prof. Cohen's way of thinking, the approach taken by the Forand bill to paying the health bill for the aged is far sounder and more conservative than that of the Javits bill or the President's proposal to subsidize voluntary commercial and nonprofit insurance companies out of general tax revenues.

Mr. Eisenhower didn't quite synchronize his timepiece with the Tri-State schedule. On opening day a panel discussed the impact of "proposed plans" on hospital costs and patient services. But the Administration's own long awaited proposal had not been announced. That came 24 hours later, recommending catastrophic health insurance for elderly persons with low incomes.

While no speaker was willing to support the Forand bill with its social security tie-in, the probable consensus on bills proposed and soon to be proposed was expressed by Ray E. Brown of Chicago, as follows:

"If we don't find ways to control the costs of hospitalization to the public and if the government does find a way, the government way is going to be crude. Quality is bound to go down under our present economic paradox: reduced funds and increasing demands."

The proposed national Blue Cross contracts, pending A.H.A. approval of reorganization in August, aren't going to be easy to set up, Bennett McCarthy of Detroit contended, for "the tremendous political and social pressures that put over the federal employes' contract" will be lacking. He predicted that national contracts will not lead to a leveling off in rates, and he foresees no uniform type of contract in the immediate future.

BARD-PARKER DISINFECTING SOLUTIONS prolong the useful life of instruments



B-P FORMALDEHYDE GERMICIDE

combines sporicidal and bactericidal potency for hospital use. Protects delicate instruments and keen cutting edges during preoperative preparation. Kills vegetative pathogens and spore formers within 5 min. — the spores themselves within 3 hrs. — TUBERCLE BACILLI WITHIN 5 MIN. Use full strength.



B-P CHLOROPHENYL Disinfectant

where sporicidal potency is not essential—a powerful instrument disinfecting solution for ward, doctor's office, dental clinic. No substitute for B-P GERMICIDE in the operating room—but destroys commonly encountered vegetative bacteria—is free from phenol (carbolic acid)—mercurials. Use full strength.



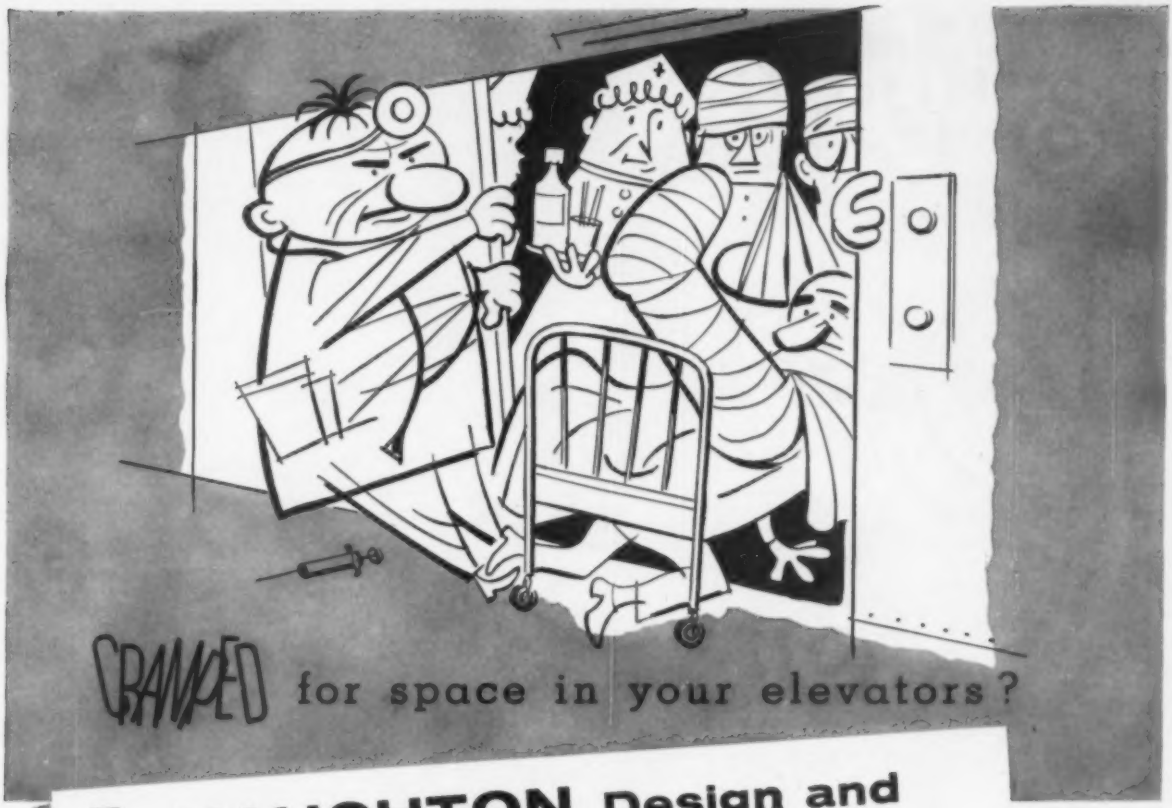
B-P HALIMIDE Concentrate Disinfectant

for inexpensive instrument disinfection. NO ANTI-RUST TABLETS TO ADD—a CONCENTRATE of low surface tension—excellent penetrating qualities. 1 oz. mixed with 1 gal. of water makes a GALLON of non-corrosive solution. TUBERCULOCIDAL WHEN DILUTED WITH ALCOHOL.

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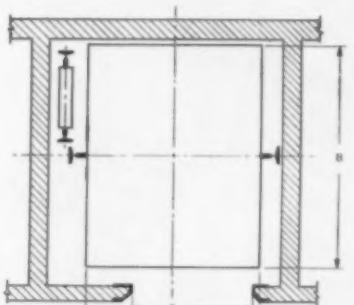
Rx-HAUGHTON Design and Modernization Services

It's no wonder many hospitals have elevator problems. Current standards for hospital elevators specify inside car width of 5′ 4″ and depth of 8′ for elevators rated at 3500 lbs. load capacity. For a 4000 lb. rating, width 5′ 8″ and depth 8′ 4″.

These recommended dimensions and capacities are just not adequate anymore.

Many hospital beds, with attachments are actually over 8½′ in length . . . an impossible "fit" in an 8′ car. And many of the new, improved iron lungs are too big for elevators designed to present standards. You can name other examples of equipment that won't fit into your elevators.

You'll be glad to know that Haughton engineers don't rely on these obsolete standards . . . but recommend equipment for today's needs on all new hospital construction and modernization jobs. This *realistic* approach will best serve the vital elevator needs of *your* hospital . . . and assure elevator service that's an asset, not a handicap.



HOSPITAL ELEVATOR STANDARDS RECOMMENDED BY HAUGHTON

LOAD	DIMENSIONS		
	A	B	C
4000 lbs.	5′4″	9′0″	4′
4500 lbs.	5′8″	9′6″	4′
5000 lbs.	6′0″	9′6″	4′

Your Haughton representative will freely consult with you without cost or obligation, so call him in soon.

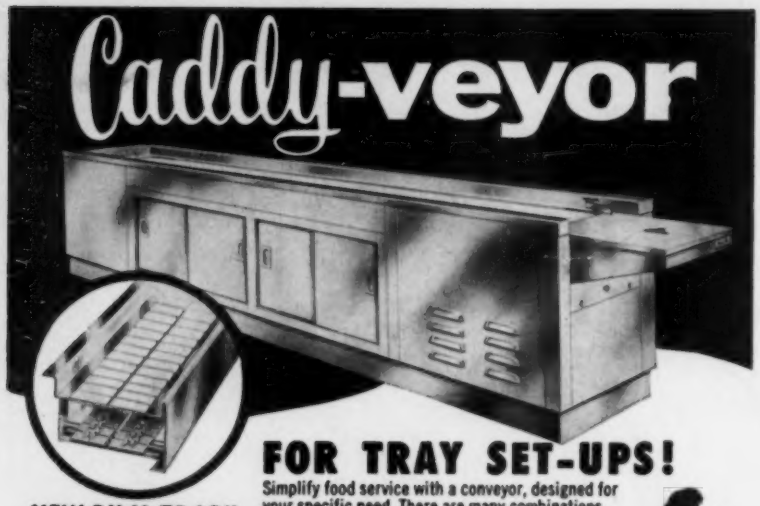
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Simplify food service with a conveyor, designed for your specific need. There are many combinations of details to choose. Durable, welded construction, designed for easy cleaning and maintenance. Installed as a complete unit . . . no expensive extras. Our engineering department is always available to assist in planning. The Caddy line also includes many portable units for handling of dishes, trays and racks.



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All the features of larger mobile resuscitators in more compact, less expensive unit. Weighs under one pound . . . can be carried in pocket . . . completely controlled at mask . . . connects to any pipe-line outlet . . . used with face mask or endotracheal tube. Provides automatic pressure-controlled respiration to patient's lung capacity . . . furnishes either intermittent positive pressure or positive-negative breathing . . . can be regulated to mixtures from 100% oxygen to 50% oxygen, 50% nitrogen.

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☐ Please arrange demonstration

NAME .....
HOSPITAL .....
STREET .....
CITY ..... STATE .....

COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Jack Tar Hotel, San Francisco, Aug. 21-26.

AMERICAN ASSOCIATION FOR HOSPITAL CONSULTANTS, Fairmont Hotel, San Francisco, Aug. 27.

AMERICAN ASSOCIATION FOR HOSPITAL PLANNING, Federal Building and Clift Hotel, San Francisco, Aug. 26, 27.

AMERICAN ASSOCIATION OF MEDICAL CLINICS, Roosevelt Hotel, New Orleans, Oct. 6-8.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Olympia Hotel, Seattle, Oct. 10-13.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Civic Auditorium and Sheraton-Palace, San Francisco, Aug. 29-Sept. 1.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Convocation, Civic Auditorium and Jack Tar Hotel, San Francisco, Aug. 27-29.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, Statler-Hilton Hotel, Dallas, Oct. 30.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, San Francisco, Oct. 10-14.

AMERICAN DENTAL ASSOCIATION, Statler-Hilton Hotel, Los Angeles, Oct. 17-20.

AMERICAN HOSPITAL ASSOCIATION, San Francisco, Aug. 29-Sept. 1.

AMERICAN MEDICAL ASSOCIATION, Miami Beach Hotel, Miami Beach, June 13-17.

AMERICAN NURSING HOME ASSOCIATION, Mayflower Hotel, Washington, D.C., Oct. 18-21.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, Oct. 31-Nov. 3.

AMERICAN PHARMACEUTICAL ASSOCIATION, Shoreham and Sheraton-Park Hotels, Washington, D.C., Aug. 14-19.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Penn-Sheraton Hotel, Pittsburgh, June 26-July 2.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Palmer House, Chicago, Sept. 27-30.

AMERICAN SOCIETY OF HOSPITAL PHARMACISTS, Shoreham and Sheraton-Park Hotels, Washington, D.C., Aug. 14-19.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Hotel Ambassador, Atlantic City, June 19-24.

ASSOCIATED HOSPITALS OF MANITOBA, Royal Alexandra Hotel, Winnipeg, Oct. 25-27.

CALIFORNIA HOSPITAL ASSOCIATION, Miramar and Biltmore Hotels, Santa Barbara, Oct. 24-28.

(*Continued on Page* 189)

NEW appetizing GEVRAL® Protein

VITAMIN-MINERAL-PROTEIN SUPPLEMENT LEDERLE

Recipes

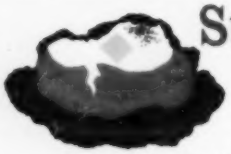


Tomato Rarebit

(4 servings)

2 cups (½ lb.) grated Cheddar cheese
1–10½ oz. can condensed tomato soup
3 tbs. water • ½ tsp. salt
Few grains cayenne (optional) • 2 tbs. GEVRAL Protein

Combine ingredients, heat, stir frequently until cheese melts. Serve on toast or crackers.



Stuffed Baked Potato

(makes 4)

4 baked potatoes (3½" diameter) • 2 tbs. butter
2 tbs. grated onion (optional) • 2 tbs. hot milk
½ tsp. salt • ¼ tsp. paprika • 2 egg whites
½ cup (¼ lb.) grated Cheddar • 2 tbs. GEVRAL Protein

Cut hot potatoes and scoop out halves; mash thoroughly with GEVRAL Protein. Sauté onion in butter and add to pulp with milk, salt, paprika. Beat smooth. Beat egg whites stiff and fold in. Fill potato shells, sprinkle with grated cheese and broil slowly till cheese melts.



Cream Soup

(4 cupfuls)

2 tbs. butter or oleomargarine • 1 tbs. minced onion
1½ tsp. flour • ¼ tsp. salt • ⅛ tsp. paprika
1 cup milk • 1 cup bouillon or vegetable water
1 cup puréed vegetable • 2 tbs. GEVRAL Protein

Melt butter, add onions, sauté 5 min. Blend in flour, salt, paprika. Stir in milk and soup base slowly; heat to boiling. Add purée and reheat to boiling. Make GEVRAL Protein paste with a little soup; add to soup and mix.



Fruit Whip

(4 servings)

⅔ cup fruit pulp • 2 egg whites • ¼ tsp. salt
3 tbs. sugar • 1 tbs. lemon juice • 2 tbs. GEVRAL Protein

Pulp cooked fruit, or use baby-junior fruits (prunes, peaches, apples). Mix slowly, thoroughly with GEVRAL Protein. Beat egg whites stiff with salt; add sugar gradually, beat glossy. Fold in fruit, and lemon juice. (For 1 serving, mix all then add 1 portion gradually to GEVRAL Protein.

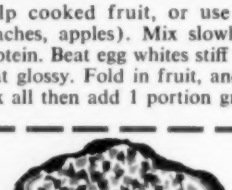


Fruit Sherbet

(4 servings)

1 cup junior pear & pineapple, canned
½ cup orange juice • ½ cup fine sugar
1 cup evaporated milk, undiluted
Few grains salt • 2 tbs. GEVRAL Protein

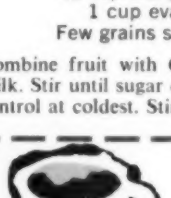
Combine fruit with GEVRAL Protein. Add juice, sugar, milk. Stir until sugar dissolves. Place in tray in freezer with control at coldest. Stir once after ½ hour. Freeze firm.



Cereals

2 tbs. GEVRAL Protein
¾ cup Cream of Wheat or 1 cup Oatmeal

Add GEVRAL Protein to cooked cereal. Or add to whole or skimmed milk over dry cereals.



Pine-Nog

(1 cup serving)

1 cup pineapple juice, canned or frozen (diluted)
1 egg • 2 tbs. GEVRAL Protein

Combine juice and egg. Gradually mix with GEVRAL Protein and stir or blend until dissolved.



Baked Custard

(4 servings)

¼ cup sugar • ¼ tsp. salt • 3 eggs • 2 cups milk
1 tsp. vanilla • 2 tbs. GEVRAL Protein

Combine sugar, salt, GEVRAL Protein: stir in beaten eggs. Add milk slowly and mix well. Add vanilla. Pour in cups and set in pan of hot water. Bake at 325° F. for 30-40 minutes or until custard sets.



Milk and fruit juices

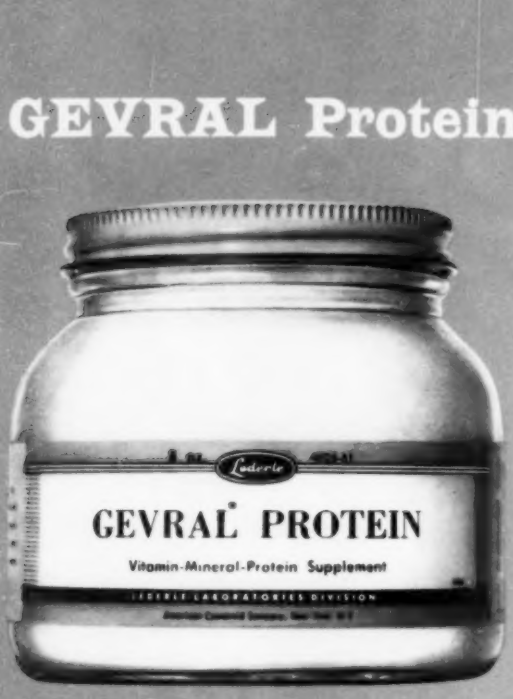
(single ½ cup serving)

Make paste with 2 tablespoonfuls GEVRAL Protein and small amount selected liquid (whole or skim milk, tomato juice, orange juice, chocolate milk). Add remaining liquid and mix thoroughly.

analysis

OTE: tamin content will be tered by heating.	GRAMS PROTEIN	FAT	CARBOHYDRATE	CALORIES
mato Rarebit serving of 4)	16.6	19.9	11.9	307
uffed Baked Potato serving of 4)	13.7	8.0	36.4	293
eam Soups serving of 4)				
a	9.4	5.6	12.5	158
een Bean	7.8	5.5	12.5	140
mato	8.1	5.7	12.6	152
nach	8.0	5.6	9.5	138
it Whip serving of 4)				
ne	6.5	.28	20.5	105
ch	6.5	.06	17.0	91
le	6.3	.06	17.6	94
it Sherbet erving of 4)	9.6	5.5	35.2	219
eals cup Cream of Wheat	21.4	.9	27.7	205
up Oatmeal	23.4	3.4	33.0	253
e-Nog p	24.9	6.3	39.3	302
ed Custard erving of 4)	13.4	9.0	20.4	216
& Juices le milk	26.5	10.0	19.0	271
n milk	26.6	.8	19.5	192
ato juice	20.4	1.1	17.4	155
ge juice	20.0	1.1	34.1	213
colate milk	26.0	6.1	33.5	290

GEVRAL Protein



Each 30 Gm. (2 heaping tablespoons) contains:	
Vitamin A (acetate)	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate (B_1)	2.5 mg.
Riboflavin (B_2)	2.5 mg.
Niacinamide	7.5 mg.
Pyridoxine HCl (B_6)	0.25 mg.
Calcium Pantothenate	2.5 mg.
Folic Acid	0.5 mg.
Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate	1/15 U.S.P. Oral Unit
Lysine	1.5 Gm.
Choline Dihydrogen Citrate	50 mg.
Inositol	25 mg.
Ascorbic Acid (C)	25 mg.
Rutin	12.5 mg.
Vitamin E (tocopheryl acetates)	5 I.U.
Calcium ($CaHPO_4$ & Calcium Caseinate)	414 mg.
Phosphorus ($CaHPO_4$)	80.9 mg.
Calcium Caseinate	21 Gm.
Ferrous Fumarate	15 mg.
Iron (as Fumarate)	5 mg.
Fluorine (CaF_2)	0.05 mg.
Copper (CuO)	0.5 mg.
Iodine (KI)	0.1 mg.
Potassium (from K_2SO_4 and Calcium Caseinate)	15 mg.
Manganese (MnO_2)	0.5 mg.
Zinc (ZnO)	0.25 mg.
Magnesium (MgO)	0.5 mg.
Boron ($Na_2B_4O_7.10H_2O$)	0.05 mg.
Carbohydrate (from malt extract and sucrose)	7 Gm.
Calories	105.3
Total Protein (Nx6.38)	60%
Sodium	.075%
Fat not more than	2%

SUPPLIED: ½ lb. jar and 5 lb. can

Excellent for High-Protein Tube Feeding GEV

60%

FORMULA & ANALYSIS

	High Volume Formulas (H	
	Formula #1	**Formul**
BASIC INGREDIENTS:		
GEVRAL PROTEIN	60 Gm. (2 oz.)	60 Gm. (2
WHOLE MILK	1 Qt.	1½ P
NON-FAT MILK POWDER	3 cups (405 Gm.)	2 cup
WATER (To Volume)	2000 cc.	1330 c
TOTAL VOLUME	**2000 cc.**	**1330 c**
PROTEIN	214 Gm.	158 G
CALORIES	2340	1686
SODIUM	2.67 Gm.	1.84 G
CARBOHYDRATE	272 Gm.	190 G
FAT	43 Gm.	32 G
VITAMINS:		
Vitamin A	6720 Unit	6278 U
Vitamin D	543 Unit	532 U
Thiamine (B_1)	6.8 mg.	6.2 m
Riboflavin (B_2)	14.6 mg.	11.5 m
Niacin	20.4 mg.	18.7 m
Pyridoxine (B_6)	3.2 mg.	2.3 m
Calcium Pantothenate	22.4 mg.	16.8 m
Folic Acid	1 mg.	1 m
Vitamin B_{12} with Intrinsic Factor	2/15 Unit	2/15 U
Vitamin B_{12} (Additional)	25 mcgm.	16 m
Choline	833 mg.	581 m
Inositol	900 mg.	616 m
Ascorbic Acid (C)	88 mg.	76 m
Rutin	25 mg.	25 m
Vitamin E	10 I.U.	10 I.
Lysine	16.4 Gm.	12.3 G
MINERALS:		
Calcium	7.26 Gm.	5.22 G
Phosphorus	5.20 Gm.	3.58 G
Iron	13.4 mg.	12.3 m
Fluorine	0.6 mg.	0.4 m
Copper	1.5 mg.	1.3 m
Iodine	0.2 mg.	0.2 m
Potassium	5.9 Gm.	4.1 G
Manganese	1 mg.	1 m
Zinc	31.5 mg.	22.1 m
Magnesium	600 mg.	390 m
Boron	0.1 mg.	0.1 m

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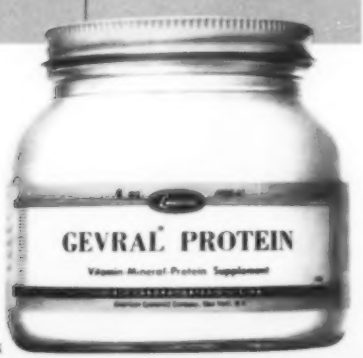
VRAL® Protein

VITAMIN-MINERAL-PROTEIN SUPPLEMENT LEDERLE

60% protein plus 26 vitamins and minerals for complete, convenient feeding

ulas (Normal Sodium Content)

rmula #2	Formula #3
Gm. (2 oz.)	60 Gm. (2 oz.)
1½ Pt.	1 Pt.
2 cups	1 cup
1330 cc.	665 cc.
330 cc.	**665 cc.**
158 Gm.	101 Gm.
1686	1031
1.84 Gm.	1.00 Gm.
190 Gm.	108 Gm.
32 Gm.	22 Gm.
6278 Unit	5834 Unit
532 Unit	521 Unit
6.2 mg.	5.7 mg.
11.5 mg.	8.5 mg.
18.7 mg.	16.9 mg.
2.3 mg.	1.5 mg.
16.8 mg.	11.3 mg.
1 mg.	1 mg.
2/15 Unit	2/15 Unit
16 mcgm.	8 mcgm.
581 mg.	328 mg.
616 mg.	333 mg.
76 mg.	64 mg.
25 mg.	25 mg.
10 I.U.	10 I.U.
12.3 Gm.	8.1 Gm.
5.22 Gm.	3.17 Gm.
3.58 Gm.	1.97 Gm.
12.3 mg.	11.3 mg.
0.4 mg.	0.3 mg.
1.3 mg.	1.1 mg.
0.2 mg.	0.2 mg.
4.1 Gm.	2.2 Gm.
1 mg.	1 mg.
22.1 mg.	12.9 mg.
390 mg.	210 mg.
0.1 mg.	0.1 mg.



New York

COMING EVENTS

(*Continued From Page 186*)

COLORADO HOSPITAL ASSOCIATION, Stanley Hotel, Estes Park, Sept. 18-20.

COMITE DES HOSPITAUX DU QUEBEC, Show Mart, Montreal, June 25, 26.

COLLEGE OF AMERICAN PATHOLOGISTS, Palmer House, Chicago, Sept. 24-27.

IDAHO HOSPITAL ASSOCIATION, Elk's Lodge, Boise, Oct. 17, 18.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 10, 11.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Oct. 12-14.

MICHIGAN HOSPITAL ASSOCIATION, Park Palace Hotel, Traverse City, June 19-21.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, June 20-22.

MISSOURI HOSPITAL ASSOCIATION, Hotel President, Kansas City, Nov. 16-18.

MONTANA HOSPITAL ASSOCIATION, Florence Hotel, Missoula, Sept. 12, 13.

NATIONAL ASSOCIATION OF BOARDS OF PHARMACY, Shoreham and Sheraton-Park Hotels, Washington, D.C., Sept. 15-19.

NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, Hilton Hotel, Albuquerque, N.M. Oct. 7-17.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 24-26.

OREGON ASSOCIATION OF HOSPITALS, Gearhart Hotel, Gearhart, Oct. 16-18.

RHODE ISLAND HOSPITAL ASSOCIATION, Sheraton-Biltmore Hotel, Providence, Oct. 4.

SASKATCHEWAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Oct. 12-14.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Masonic Temple, Mitchell, Oct. 25, 26.

WEST VIRGINIA HOSPITAL ASSOCIATION, White Sulphur Springs, Sept. 22-24.

A.I.A. Chapter Gets Funds for Hospital Design Study

NEW YORK. — A grant for hospital design research has been made to the New York chapter of the American Institute of Architects.

The grant, which was awarded by the U.S. Public Health Service, is the first of its kind ever given to a chapter of the A.I.A., according to James L. Souder, chairman of the hospital and health committee of the New York chapter.

University Hospital Settles With Union on Pay Raises

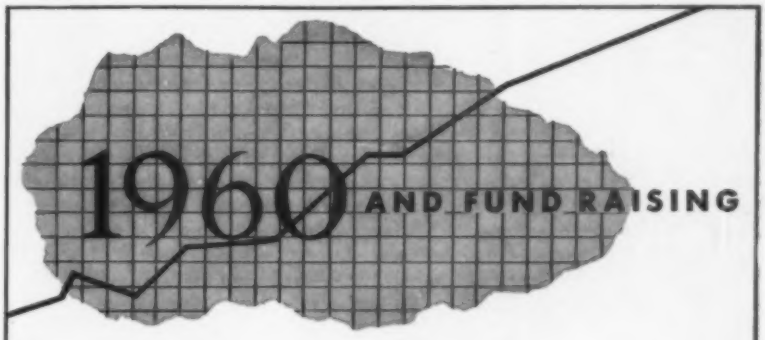
NEW YORK. — After months of negotiation between union and hospital officials, University Hospital here has granted pay raises to 700 nonprofessional employes.

Robert Kerley, business manager of the hospital, announced the increase in a letter to Local 1199, Drug and Hospital Employes Union.

Although Leon J. Davis, president of the local, said the union had won recognition and bargaining rights, Mr. Kerley denied that a formal contract had been signed, according to the *New York Times*.

Mr. Davis said the letter was, in effect, an agreement since it had come after the union had showed the hospital authorities membership cards for almost 90 per cent of the nonprofessional employes and after a strike had been voted.

The hospital approved increases of $10 a month, retroactive to January 1, for all employes now earning $350 or less a month, the *Times* reported. The minimum starting rate was raised from $40 to $45 for a 40 hour week.



FROM the vantage point of 40 years of successful experience, we believe that 1960 offers the most favorable climate that has ever prevailed for hospital fund raising.

The nation's economic strength and the advance of philanthropy to a new high suggest action by hospitals considering new additions or the renovation of existing facilities.

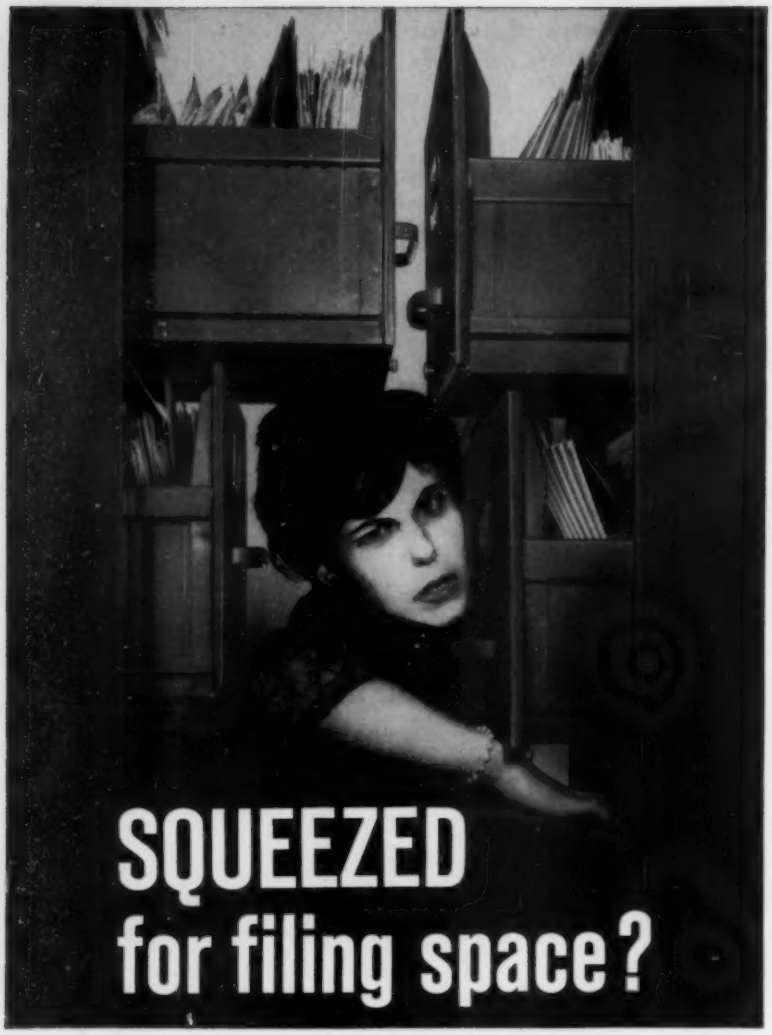
Increasingly, hospitals turn to Tamblyn and Brown, Inc. for: 1) study and counsel concerning the justification and success potential of a fund campaign, and 2) organization and direction of an individualized campaign that builds good will while attaining gratifying results.

Additional information that may help your hospital will be given gladly upon request, without cost or obligation.

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Diverse Groups Exchange Health Insurance Views at A.M.A. Conference

CHICAGO. — Representatives of labor, business, farm groups, consumers, insurance companies, and the medical profession got together here last month to tell where they stand on prepaid health insurance.

More than 30 national organizations and 34 state medical associations participated in the Congress on Prepaid Health Insurance, sponsored by the American Medical Association.

In case anyone thought the meeting foreshadowed any shift in the A.M.A.'s position, they were set straight at the start by Dr. J. Lafe Ludwig, chairman of the A.M.A.'s Council on Medical Service.

"It would be unfair to all those attending . . . if the misconception persisted that this is a bargaining session involving the A.M.A. and representatives of labor," Dr. Ludwig told the congress in his opening remarks.

The proponents of group medical practice heard their position summarized by Dr. Frederick D. Mott, executive director of Community Health Association of Detroit. Pointing to the need for experimentation in the medical care field, he stated:

"Just as a Blue Cross plan laudably experiments with coverage for mental illness or a Blue Shield plan tries out a relative value schedule, we in the group practice plans want freedom to exist, to experiment, and to grow if we deserve to grow. . . . This movement has the right to be free from harassment as it does its modest part in seeking solutions to the grave problems facing us all."

Insurance Official Upheld on Blue Cross Rate Ruling

BISMARCK, N.D. — The state attorney general has upheld the authority of the North Dakota Commissioner of Insurance to set Blue Cross rates.

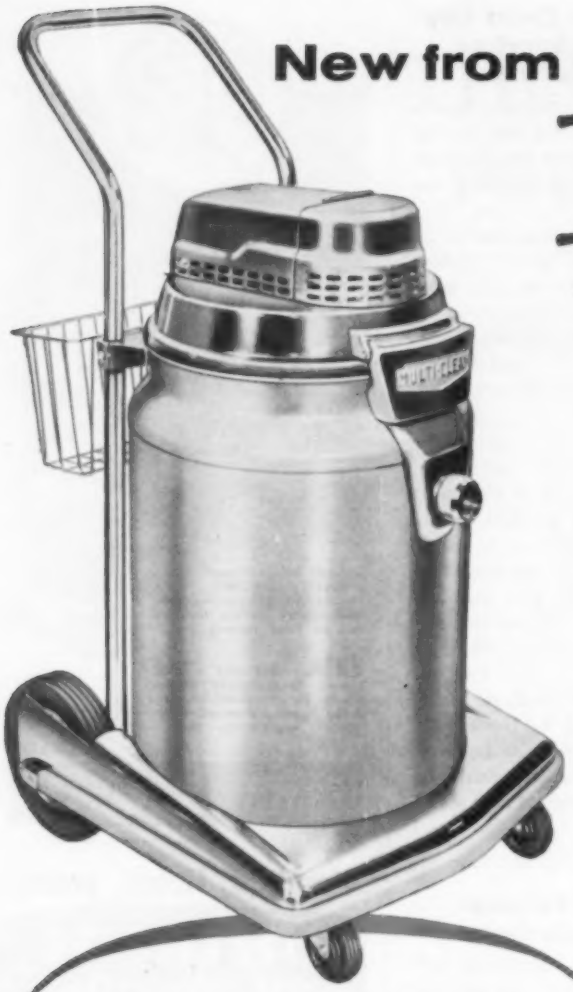
The commissioner, A. J. Jensen, had asked for an opinion after Blue Cross challenged his authority to disapprove a recent request for a rate increase of 24 per cent.

The attorney general's ruling was based on a statutory provision that contracts with subscribers, contracts with hospitals, and operating costs of insurance programs are subject to the approval of the commissioner.

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The new Multi-Clean IMPERIAL line of Vacuum Cleaners consists of 3 series: the IMPERIAL "5" (½ hp), IMPERIAL "10" (1 hp), and IMPERIAL "15" (1½ hp). Each of these power units may be used with 7, 12, and 17-gallon tanks and with a Kon-Vert-O-Vac attachment on a 55 gallon drum; thus power and tank capacities can be tailored to your needs.

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It's Rugged! Despite their handsome, elegant styling, the Multi-Clean IMPERIALS have the heavy duty construction needed to make them real work horses. Motors, too, last longer.

This is because power for the IMPERIAL "10" and "15" Series Vacs comes from special heavy-duty motor units designed and built by Multi-Clean exclusively for this purpose. They turn at 12,000 rpm with no load and 9,550 rpm with full load. This is *much slower* than the speed at which most other vacuum motors must operate in order to create the same suction. This slower speed means less wear, longer life.

It's Easier to Operate! The IMPERIAL is designed with the user's convenience in mind.

The tank, for example, has a non-clogging gravity drain. It can be emptied of liquids without disturbing the head. Large gray wheels make it easier to move up and down stairs or from building to building. In addition to the wheels, it also has two ball bearing gray swivel casters. This makes it virtually tip-proof by providing support at 4 points instead of the usual 3 . . . an important factor when we realize a 17-gallon Vacuum Cleaner weighs about 300 lbs. when full!

More Features! Patented, washable filter is pleated to provide 1400 sq. in. of filter area. It's made from a special quick-drying synthetic fibre that won't rot or mildew. Can be washed, rinsed, and drip-dried in minutes . . . 30-foot, 3-conductor cable has same twist lock connector as most Multi-Clean Floor Machines. If you wish, same cable can be used for both . . . Stabilized motor brushes (an exclusive, patented Multi-Clean feature) outlast standard brushes 2 to 1.

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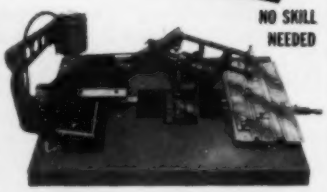

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Nursing Homes Cheat City by Inadequate Services, New York Study Finds

NEW YORK. — Nursing homes here have been cheating the city by providing fewer services than they are being paid for, an investigator has reported.

Investigation Commissioner L. I. Kaplan reported to Mayor Robert Wagner that some homes also falsified reports to the Department of Hospitals on their staffing, incorrectly indicating that they had the required number of nurses or attendants.

Mr. Kaplan found that because the city paid $150 to $200 a month for each municipal patient in a nursing home, it had been cheated in instances where payments were based on services not fully rendered. An informal estimate was that the lack of proper services has cost the city about $3 million, the *New York Times* reported.

On the basis of the findings, Mayor Wagner has ordered a "crackdown" on all nursing homes that failed to meet both structural standards for their buildings and patient care standards.

Johns Hopkins Receives Two P.H.S. Study Grants

BALTIMORE. — Research into problems of hospital staffing and services to patients will be undertaken here at Johns Hopkins Hospital under two U.S. Public Health Service grants.

The studies will be made by the hospital's operations research division and will be directed by Dr. Charles D. Flagle, according to the hospital.

The grants, which total $248,000, will be used to develop findings that are applicable to hospitals in general, it was explained.

Two studies are contemplated. One was described as an attempt to analyze the factors involved in the nursing care of inpatients and try to determine how to make the best use of nursing skills and hospital equipment.

The other will investigate the pattern of accidents and illnesses that send patients to the clinics of a hospital in an attempt to discover the medical and administrative services which these patients require.



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ABOUT PEOPLE

(*Continued From Page* 120)

Truman Yates has been appointed administrator of Doctors Hospital, Phoenix, Ariz. Mr. Yates has been administrator of Parkview Hospital, Yuma, Ariz., and assistant administrator of Good Samaritan Hospital, Phoenix.

Carl A. Virgien has resigned as administrator of Jane Chinn Memorial Hospital, Webb City, Mo., and has accepted the post of administrator of Bates County Memorial Hospital, now under construction at Butler, Mo. Mr. Virgien formerly was business manager at Freeman Hospital, Joplin, Mo., before going to Jane Chinn. **Oakie Ray Shepard** succeeds Mr. Virgien.

Donald L. Laughlin has been appointed assistant administrator of Pennsylvania Hospital's department for the sick and injured, Philadelphia. Mr. Laughlin received his master's degree in hospital administration from the University of Toronto and served his administrative residency at Pennsylvania Hospital. He also served as administrative assistant at Abington Hospital, Abington, Pa. His next assignment was as research associate with the Hospital Council of Philadelphia. Mr. Laughlin then became administrator of the Levittown Public Recreation Association until accepting his appointment at Pennsylvania Hospital.

Edward J. Bissa Jr. has been appointed administrator of Johnston Memorial Hospital, Tishomingo, Okla. Mr. Bissa is a former laboratory technician at Park View Hospital, El Reno, Okla., and also worked at St. Anthony Hospital and Wesley Hospital, Oklahoma City.

Tom N. Jackson has been appointed administrator of Willcox Hospital, Willcox, Ariz.

Jewell McNatt is the new administrator of Hoemako Hospital, Casa Grande, Ariz.

Elton W. Barclay has been appointed administrator of J. Lewis Crozer Hospital, Chester, Pa., succeeding **Dr. John T. Bennett,** who is retiring. Mr. Barclay is former administrator of Stetson Hospital, Philadelphia.

John F. Haines has assumed his new post as assistant administrator of Alexian Brothers Hospital, St. Louis. Mr. Haines had been administrative resident at Luther Hospital, Eau Claire, Wis., after receiving his master's degree in hospital administration from the University of Iowa in 1958.

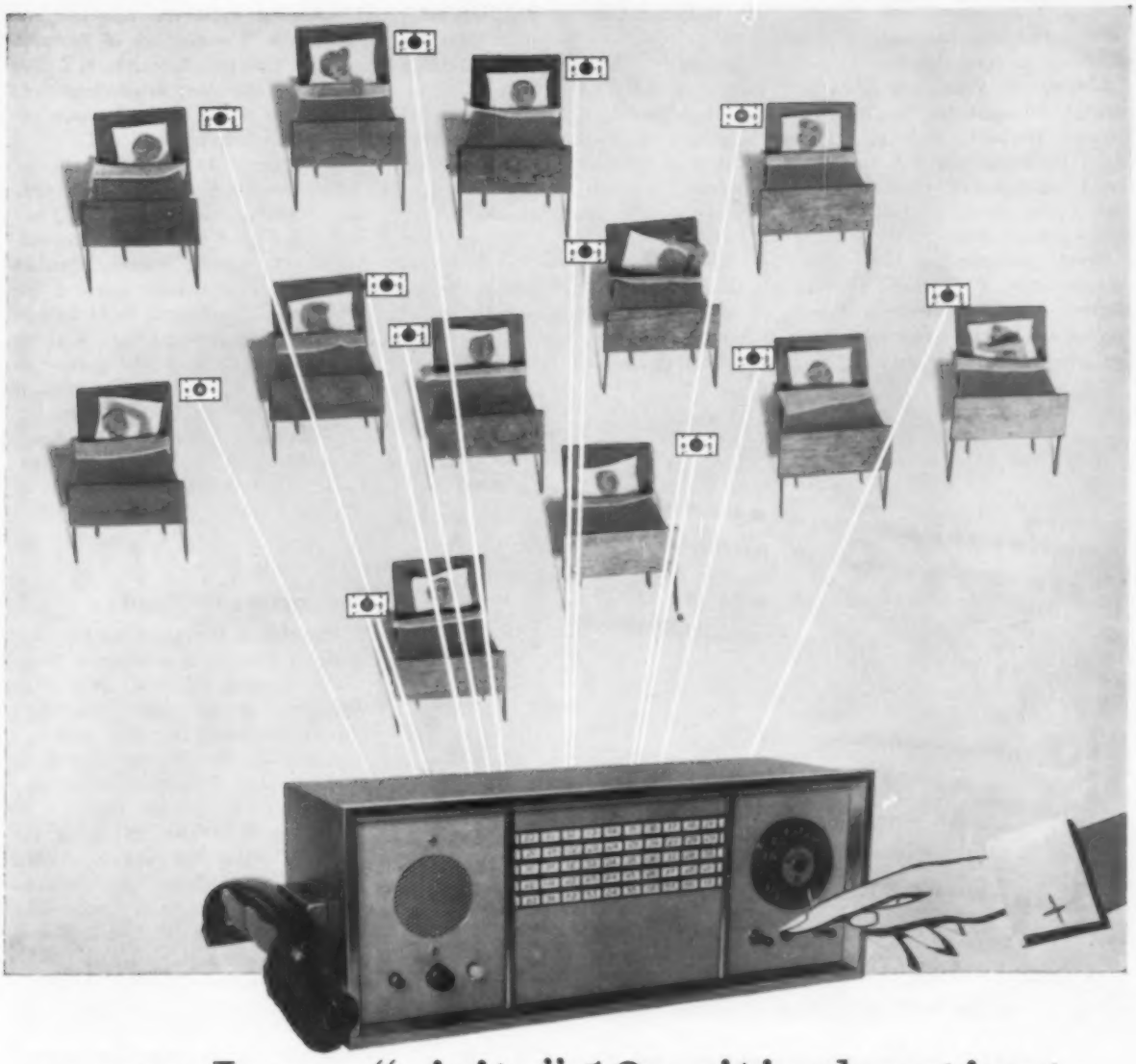
Dr. Sim Penton has been named to succeed **Dr. Robert K. Oliver** as administrator of Montgomery Tuberculosis Sanatorium, Montgomery, Ala. Dr. Oliver will become administrator of Hale Memorial Tuberculosis Hospital, Tuscaloosa, Ala.

Robert T. Trautman has been appointed administrator of Oceana Hospital, Hart, Mich., succeeding **Edna Burtenshaw,** who has resigned. Mr. Trautman was a resident in hospital administration at Blodgett Hospital, Grand Rapids, Mich.

Stuart Ogren, former administrative assistant at Orange Memorial Hospital, Orlando, Fla., has assumed the position of assistant executive director of the Michigan Hospital Association. Mr. Ogren served his administrative residency at Orange Memorial.

E. E. McDonal has been appointed administrator of Okaloosa Memorial Hospital, Crestview, Fla., succeeding **O. D. Dickerson,** who has been ap-





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pointed administrator of Calhoun General Hospital, Blountstown, Fla., scheduled to open this summer.

Richard S. Palm has been appointed administrator of Bad Axe General Hospital, Bad Axe, Mich. Mr. Palm earned his B.A. in institutional management from Michigan State University with a major in hospital administration.

Orval Sparkman has been named administrator of Hartselle Hospital, Hartselle, Ala., where he had been serving as assistant administrator under **John Guier,** who has resigned.

William Adams has been appointed administrator of Liberty Memorial Hospital now under construction in Hinesville, Ga.

Capt. Audrey C. Holm was named superintendent of Booth Memorial Hospital, Spokane, succeeding **Capt. Merle Carpenter,** who was transferred to Anchorage, Alaska.

John Barrett has been appointed administrative assistant at Memorial Hospital of Chatham County, Savannah, Ga. Mr. Barrett recently graduated from the Emory University School of Hospital Administration.

Maud J. West has resigned her position as administrator of Prospect Heights Hospital, Brooklyn, N.Y. Before her assignment as administrator, Mrs. West served in the business office of the hospital.

Dr. Vincent I. Bonafede, assistant administrative director of Craig Colony and Hospital, Sonyea, N.Y., has been promoted to director, succeeding **Dr. George L. Warner,** who has retired. Dr. Bonafede received his M.D. from the University of Buffalo and has done postgraduate work in neuropsychiatry and tuberculosis research; he has also been assistant clinical director at Craig Colony. Dr. Bonafede is a diplomate of the American Board of Psychiatry and Neurology and the American Board of Mental Hospital Administrators.

Department Heads

Nanette D. Robertson has been appointed director of dietetics at Overlook Hospital, Summit, N.J. Miss Robertson has been dietary consultant to New Jersey hospitals under a grant from the division of chronic illness control of the State Department of Health.

Robert A. Walsh has been appointed to the dual position of chief pharmacist at Peter Bent Brigham Hospital, Boston, and professorial lecturer in public health at Massachusetts College of Pharmacy. He succeeds **Ernest Lentini,** who resigned to accept a commission in the U. S. Public Health Service. The hospital also announced the appointment of **E. Jane Deckert** as director of the dietary department. Miss Deckert succeeds **Madge Myers,** who is now in the department of nutrition of the Harvard School of Public Health. Miss Deckert had been director of the dietary department of Temple University Hospital, Philadelphia.

Jack Heard has been named to succeed **Albert Schwabe** as chief pharmacist at St. Francis Memorial Hospital, San Francisco. Mr. Heard is former chief pharmacist at University of California at Los Angeles Hospital. At the same time, it was announced that **Francis Gates** succeeded **Jack J. Beckerman** as controller.

Michael L. Redmond has been appointed purchasing director of Louis A. Weiss Memorial Hospital, Chicago. Mr. Redmond received his B.S.

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from Northwestern University and studied civil engineering at the University of Illinois. He was in business prior to his recent appointment.

Kathryn Groenevelt has been named associate director of nursing at Butterworth Hospital, Grand Rapids, Mich.

Shauna Holmes has been named director of nursing and **Mrs. Darrell Tullis** has been appointed dietitian at Weber County Chronic Disease Hospital, Roy, Utah. Mrs. Tullis was dietitian at St. Mark's Hospital, Salt Lake City, while Miss Holmes served at Thomas D. Dee Hospital, Ogden, Utah.

Miscellaneous

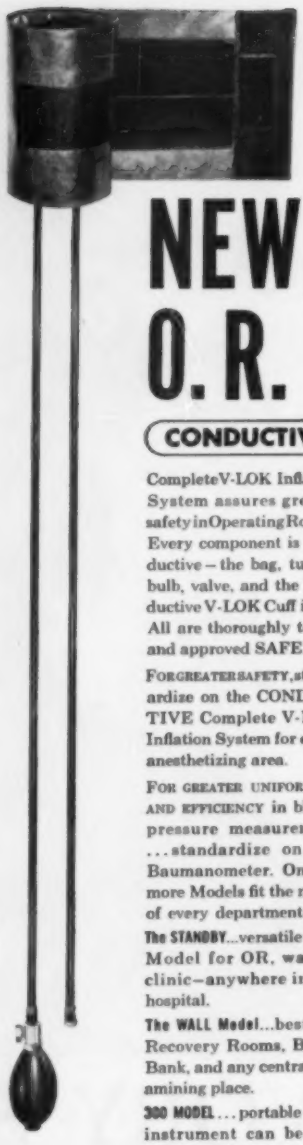
Lt. Col. Katherine E. Manchester, AMSC, will become chief of the dietitian section and assistant chief of the Army Medical Specialists Corps, succeeding **Lt. Col. Helen M. Davis,** AMSC, who will retire this summer. Lt. Col. Manchester has served as chief food service division, at 130th Station Hospital, and as food service consultant to the chief surgeon, Headquarters, U.S. Army Europe.

Merle F. Wentz has been named assistant area medical administrator of the United Mine Workers of America Welfare and Retirement Fund, Birmingham, Ala. Mr. Wentz has been administrative assistant in charge of hospital relations in the fund's office at Louisville, Ky. He has been administrator in the medical department of the United States Army and has held posts in the War Assets Administration and the U.S. Department of Agriculture.



M. F. Wentz

Dr. Oreon K. Timm has been appointed deputy to the V.A. assistant chief medical director for operations, Washington, D.C. Dr. Timm, currently Area Medical Director for the Veterans Administration, St. Paul, was formerly manager of Danville V.A. hospital, Danville, Ill., and has served at V.A. hospitals in Palo Alto, Calif., and Battle Creek, Mich. Dr. Timm received his M.D. from Washington University, St. Louis, and is a diplomate of the American Board of Psychiatry and Neurology.



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ANESTHETIST—Nurse; immediate opening; attractive schedule. Write or call for details. Miss Garnett, MOUNDS PARK HOSPITAL, 200 Earl Street, St. Paul, Minnesota. Phone PR 4-5901.

ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; $500; new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

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DIETITIAN—Immediate opening; ADA registration preferred; well equipped dietary department in 440-bed hospital; excellent personnel policies and fringe benefits, including retirement; $450 per month starting salary. Write to Personnel Department, SUTTER COMMUNITY HOSPITALS, 2820 "L" Street, Sacramento 16, California.

DIETITIAN—ADA for therapeutic work; salary $4,030 plus vacation, sick leave, choice of two pension plans, drugs at discount, free meals while on duty and free laundry of uniforms; excellent working conditions. Write Personnel Manager, DUVAL MEDICAL CENTER, Jacksonville 6, Florida.

DIETITIAN—Position being created by opening of 120-bed rehabilitation addition to Iowa Methodist Hospital; excellent opportunity for ADA registered hospital trained person; possibility of work in either therapeutic or administrative areas; good pay, liberal benefits. Apply Personnel Director, IOWA METHODIST HOSPITAL, Des Moines 14, Iowa.

DIETITIAN—Therapeutic; 253-bed J.C.H.A. approved general hospital, new kitchen and cafeteria. Send resume including experience and salary desired to Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

DIETITIAN—Immediate opening; attractive schedule. Write or call for details. Miss Garnett, MOUNDS PARK HOSPITAL, 200 Earl Street, St. Paul, Minnesota. Phone: PR 4-5901.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, BARNES HOSPITAL, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Therapeutic; new 516-bed approved cancer research hospital; $4668.00 to start for 40 hour week and liberal fringe benefits; Apply to Personnel Director, ROSWELL PARK MEMORIAL INSTITUTE, 666 Elm Street, Buffalo 3, New York.

DIETITIANS—Staff or therapeutic; ADA approved; needed at once; approved, private, non-profit, 604-bed general hospital; good employee benefits; laundry service and meals; salary open. Apply to Miss Jo Ann Brown, Personnel Director, AKRON CITY HOSPITAL, 525 E. Market Street, Akron, Ohio.

DIETITIAN—Chief; A.D.A; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 week vacation; also: Assistant dietitian; salary open, 2 week vacation, 2 meals and laundry furnished; 40 hour week, 6 holidays; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—A.D.A. preferred but not essential; 71-bed general hospital; liberal personnel policies; located in winter and summer resort area. Write: stating references and salary desired to Personnel Director, KERBS MEMORIAL HOSPITAL, St. Albans, Vermont.

DIETITIAN—Vacancies in a chain of ten general hospitals with active APC's operated in coal mining region of eastern Kentucky, southwestern Virginia and southern West Virginia; ADA membership required with experience in administration, teaching and/or therapeutics; food clinic experience desirable; salary at the rate of $4,860 or $5,880 per annum, depending upon experience and training; 40 hour week, 4 weeks paid vacation, 7 paid holidays, laundry of uniforms; social security, employees health plan. Call or write: THE MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, 110 Logan Street, Williamson, West Virginia. Phone: BELmont 5-2424.

(Continued on page 202)

classified advertising

POSITIONS OPEN

DIETITIAN—Prefer A.D.A. but not required; full time between two recently expanded 60-bed general hospitals located 12 miles apart, new dietary facilities included; easy driving distance to Madison, Milwaukee, Rockford and Chicago; salary consistent with training and experience; six holidays; liberal personnel policies; Blue Cross and physicians service available. Send resume, including references, experience, date available and salary desired to Mr. Charles E. Welch, Administrator, MEMORIAL COMMUNITY HOSPITAL, Edgerton, Wisconsin.

DIRECTOR SCHOOL OF NURSING—For N.L.N. accredited diploma school; student body of 130; Master's degree required; liberal personnel policies, excellent working conditions; attractive salary open, based on preparation and experience. Apply MO 309, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING—Modern, nonprofit, J.C.A.H. accredited, 125-bed general hospital; approved residency program; staff, Board Certified Specialists; dynamic, expanding organization; complete modern facilities; experience in nursing service, supervision and administration preferred; Master's or Bachelor's Degree required; $8,000 to $10,000 yearly, depending on qualifications; excellent personnel policies; all advantages of gracious living in beautiful suburb adjacent to Detroit, Michigan. Apply MO 302, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR NURSING SERVICE—300-bed general hospital; strong supervisory experience necessary; excellent opportunity for the person who qualifies in personality, training and experience; salary open; located northeastern Illinois. Submit complete resume and salary desired to MO 307, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING EDUCATION—Assistant; general 204-bed County hospital, 75 miles from San Francisco, coastal resort area; opportunity to develop nursing staff training programs; salary open; liberal benefits, 3 weeks vacation; B.S. Nursing Education. Apply SANTA CRUZ COUNTY PERSONNEL DEPARTMENT, 105 Soquel Avenue, Santa Cruz, California.

DIRECTOR OF NURSING SERVICE—R.N., M.S. degree in nursing service preferred; 300-bed JCAH accredited general hospital, completely new, modern and excellent facilities; liberal personnel policies, salary open. Apply ST. JOSEPH'S HOSPITAL, South Bend, Indiana.

DIRECTOR OF NURSING—Modern, nonprofit 286-bed general hospital; fully accredited, approved internship, residency programs; to expand to 470-beds; located in beautiful suburban setting close to Detroit; require master's degree with major in nursing service and administrative experience; salary dependent upon experience and qualifications. Write Director's office, OAKWOOD HOSPITAL, Dearborn, Michigan.

DIRECTOR OF NURSING — Immediate opening in modern, newly built tuberculosis hospital, 77-beds, operated by the State of Ohio; good salary, paid vacation, holidays, liberal sick leave cumulative up to 90 days, State retirement plan, and 40-hour week; a fully furnished apartment is available for low rent. Write to Director, SOUTHEAST OHIO TUBERCULOSIS HOSPITAL, Box 359, Nelsonville, Ohio.

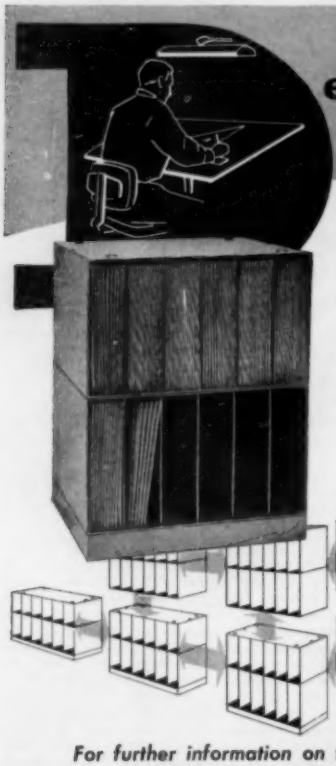
DIRECTOR OF NURSING SERVICE—242-bed, general, accredited hospital; experience desirable; excellent starting salary; progressive policies. Write James G. Carr, Jr., Administrator, MEMORIAL HOSPITAL OF NATRONA COUNTY, Casper, Wyoming.

DIRECTOR—Personnel; to organize and establish a centralized personnel department in a hospital which will have 253-beds and 44 bassinets upon completion this summer of a large expansion and remodeling program; candidate must have had good experience in this field; degree desirable; salary open; Send detailed resume of training, experience and salary desired to Robert G. West, Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

HOUSEKEEPER—Executive; large university affiliated hospital in New York State; prefer formal educational background in field; must be able to participate in top management. Apply MO 305, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTOR—Clinical; obstetric nursing; 225-bed hospital, J.C.A.H. accredited hospital; N.L.N. provisionally accredited school of nursing; 100 students; post graduate course or B.S. degree and teaching experience required; liberal personnel policies. Apply to Director of Nursing Education, ALLEN MEMORIAL HOSPITAL, Waterloo, Iowa.

(Continued on page 204)



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Illustration at left consists of:
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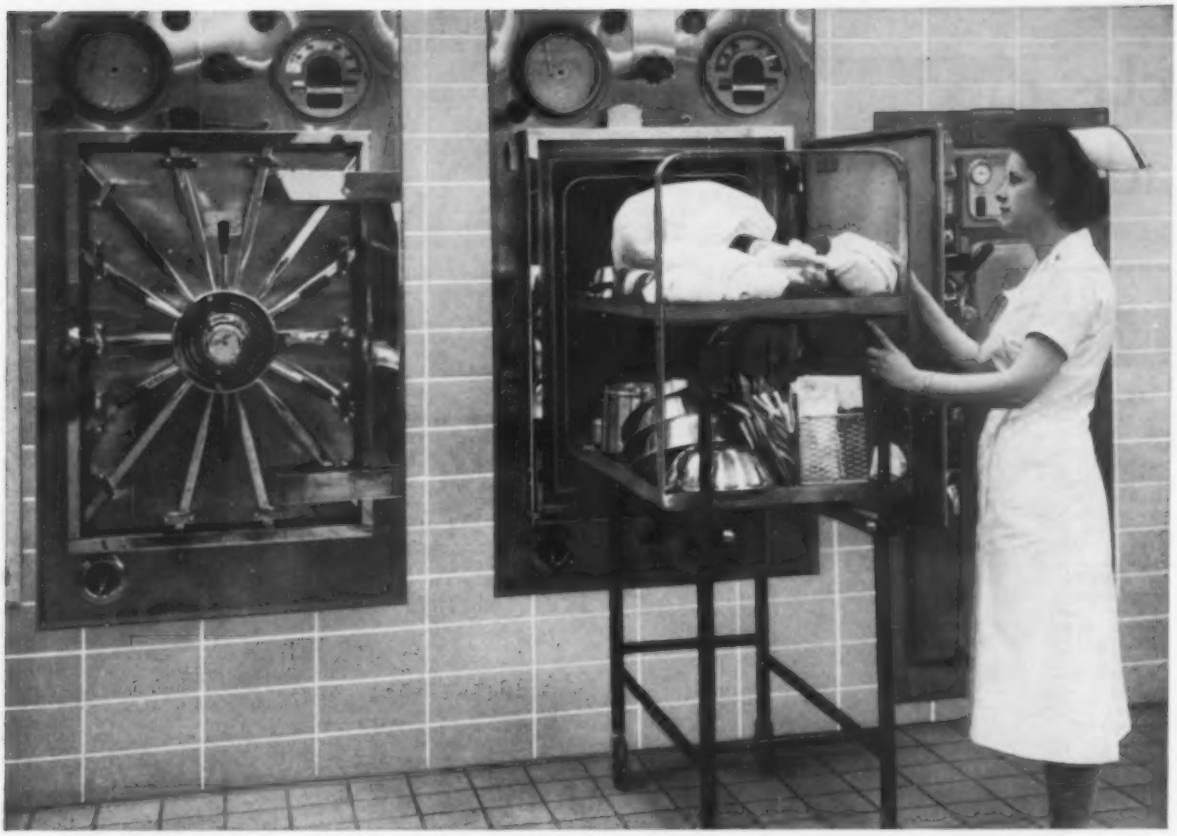
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It's a practical reality today: effective *routine* sterilization for potential transfer agents of staphylococcus ... blankets, pillows, rubber sheeting, mattresses, bassinets, infant incubators and other supplies sensitive to heat and moisture.

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If you're modernizing, expanding or planning a new hospital, consider the advantages of Nickel-clad steel and Monel alloy—used consistently by Castle in all its sterilizers. Write Wilmot Castle Company, Rochester, N.Y. for information on its sterilizers. And for information on Nickel-clad steel and Monel alloy, write to us at:

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POSITIONS OPEN

INSTRUCTORS—Medical surgical and nursing arts; minimum requirements B.S. nursing education, plus experience; NLN fully accredited; enrollment 150-180; 3 year diploma school; very active non-sectarian 576-bed general hospital; liberal personnel policies; classroom and clinical teaching; no nursing service responsibilities. Write MO 306, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTORS—Clinical; one nursing arts, one medical-surgical, also one evening supervisor; excellent personnel policies. Apply Director of Nursing, BUFFALO GENERAL HOSPITAL, Buffalo 3, New York.

INSTRUCTORS — Medical-surgical; fundamentals of nursing; and medical-surgical specialties; 225-bed hospital; N.L.N. provisionally accredited school of nursing, 100 students; B. S. and teaching experience desirable; liberal personnel policies; minimum salary for qualified person $400 per month. Apply to Director of Nursing Education, ALLEN MEMORIAL HOSPITAL, Waterloo, Iowa.

INSTRUCTOR—Clinical; to teach medical-surgical nursing in university school of nursing connected with large medical center; Master's degree in nursing required; academic appointment for this position; liberal personnel policies. For further information write Director, School of Nursing, UNIVERSITY OF OKLAHOMA, Oklahoma City 4, Oklahoma.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern ; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

LIBRARIAN—Medical records assistant; 670-bed general hospital with large out patient service; I.B.M., terminal digit and sound-ex procedures; opportunity to supervise large staff; liberal personnel policies. Apply Personnel Director, HARPER HOSPITAL, Detroit 1, Michigan.

LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

LIBRARIAN—Assistant medical records; registered, for 279-bed fully accredited general hospital in outstanding suburban community; excellent personnel policies and benefits; teaching program for interns and residents; in 4th year with P.A.S.; modern office equipment, full record department staff, cooperative medical staff; salary commensurate with experience. Contact: Director of Personnel, THE GREENWICH HOSPITAL ASSOCIATION, Greenwich, Connecticut.

LIBRARIAN—Medical records; $379 to $470 per month; college graduate in medical records; appointments above minimum may be made. Apply RAMSEY COUNTY CIVIL SERVICE DEPARTMENT, 1845 Court House, St. Paul 2, Minnesota.

LIBRARIANS—Registered medical record; Positions in two of ten general hospitals located in eastern Kentucky, southwestern Virginia, and southern West Virginia, operating on a regional pattern; one position can be filled by a recent graduate, other position requires 5 years experience for consultative duty to community hospitals in region; salary $4440 and $4860 per annum; 40 hour week, 7 paid holidays, 4 weeks vacation, social security, employee health and increment program. Write: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box 61, Williamson, West Virginia.

NURSES—Psychiatric; rewarding careers for both men and women as professional nurses in nation's largest Federal mental hospital; progressive teaching program and opportunities for participation in National Institutes of Health research projects; beautiful hospital grounds in residential section near U.S. Capitol; several near-by universities offer opportunities for advanced education; positions are for staff, head and supervisory nurses in career civil service with the Department of Health, Education and Welfare; annual salaries range from $4040 to $8230, depending upon education, experience and prior Federal service; liberal fringe benefits include group health and life insurance, retirement benefits, and generous vacation and sick leave. Write Director of Nurses, Office H, SAINT ELIZABETHS HOSPITAL, Washington 20, D. C.

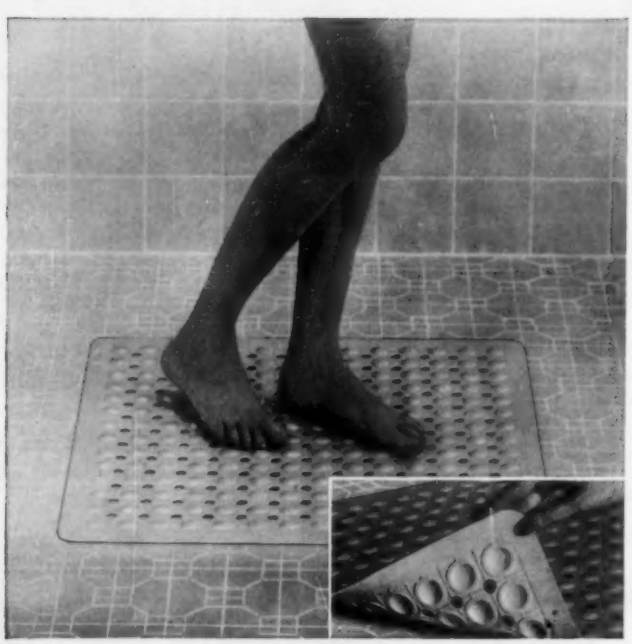
NURSES—Registered; 100-bed hospital; general staff beginning salary $220.00, complete maintenance; 3-11 and 11-7 supervisor $260.00, complete maintenance; liberal fringe benefits. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

(Continued on page 207)

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5 steps recorded on Ektachrome Film

People, long ago, had words for it . . . "One picture is better than a thousand words." True then; truer than ever today, when words and color illustrations may be combined to outline the steps in any technic or procedure. Surely, every physician who has a story to tell—procedures to describe—should investigate color photography. The cost of equipment and processing is small, the rewards great.



1. Equipment for splenic manometrics: Saline manometer; cups with contrast material, procaine, skin antiseptics and saline; syringes; connecting plastic tubes; stopcocks; needles; forceps.



2. With patient in supine position on x-ray table, tube is centered over upper abdomen. Radiographs are made serially one per second during injection over a period of 15 seconds, after which they are obtained at 5-second intervals.



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4. Pliable plastic tube connects saline manometer to needle. Splenic pulp pressures, corrected to the level of right atrium, indicate portal pressures.



5. Contrast material is being injected rapidly into splenic pulp as radiographs are obtained. (Figure 2).

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POSITIONS OPEN

STAFF POSITIONS—All clinical areas including psychiatry, respiratory-rehabilitation center; beginning salary $300 monthly; periodic increases; 3 weeks annual vacation; opportunity for college study, bachelor's degree program. Write Head, Department of Nursing Service, EUGENE TALMADGE MEMORIAL HOSPITAL, MEDICAL COLLEGE OF GEORGIA, Augusta, Georgia.

NURSES—Registered; operating room, delivery room and general duty for 350-bed hospital in western suburb 16 miles west of Chicago's loop; starting salary for experienced operating room nurses $400.00; starting salary for delivery room nurses $365.00; starting salary for general duty $350.00; differential of $15 for PM and night shifts; 6 paid holidays and other liberal benefits. Apply Mrs. Emily Strong, Personnel, MEMORIAL HOSPITAL, Elmhurst, Illinois.

PHARMACIST—Registered; male or female; for 400-bed general hospital in Hawaii, liberal personnel policies, hospitalization coverage, group life insurance, retirement, 40 hour week; starting salary $497.00. Write Personnel Director, THE QUEEN'S HOSPITAL, P.O. Box 861, Honolulu, Hawaii.

PURCHASING AGENT—Career intended, experienced, or in lieu of purchasing experience, previous background of hospital supply sales for modern, 500-bed general non-profit hospital; position open immediately; submit complete resume of experience with first reply. Frank J. Walter, Administrator GOOD SAMARITAN HOSPITAL, 1015 N. W 22nd Avenue, Portland 10, Oregon.

PURCHASING AGENT—Male; for medium-large hospital in Pittsburgh; excellent growth potential; hospital experience required. Submit resumé to Executive Director, MONTEFIORE HOSPITAL, Pittsburgh 13, Pennsylvania.

SUPERVISORS — Medical and surgical; modern, 235-bed hospital; B.S. degree, three to five years nursing experience, at least one year as head nurse required; starting salary $425.00, increments to $475.00 in 4 years; progressive personnel policies; attractive apartments on grounds; educational and cultural advantages of Detroit, coupled with pleasant suburban living. Apply Director of Nursing, OAKWOOD HOSPITAL, Dearborn, Michigan.

SUPERVISOR—Operating room; 200-bed general hospital; NLN fully accredited school of nursing; 40 hour week, salary open; liberal personnel policies. Apply Director of Nursing, BENEDICTINE HOSPITAL, Kingston, New York.

SUPERVISOR—Pediatric; new, modern, well equipped 40-bed, fully accredited general children's hospital; degree and experience in pediatrics preferred; salary commensurate with qualifications. Apply Administrator, MARY BRIDGE CHILDREN'S HOSPITAL, Tacoma 5, Washington.

(Continued on page 208)

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SUPERVISOR—Obstetrical; responsible for the administration of a 53-bed obstetrical unit consisting of a delivery room and two floors; present hospital has 575-beds; starting a $2,500,000 building in the Fall which will house an entirely new obstetrical unit; department has full time obstetrical instructor; large school with no recruitment problem; salary $4740 with six month increases to $5340; retirement plan in addition to social security; hospital pays 5% of salary into fund and employee 3%; after 5 years of service, hospital provides a life insurance policy for the employee equivalent to a year's salary; hospital pays the policy; other liberal personnel policies and attractive living and teaching facilities; each room in the residence has its own bath and shower; hospital located in a beautiful 40 acre park; community has many cultural opportunities; one college in city; four universities have extension center or extension courses in the city qualifications: Baccalaureate Degree and past supervisory experience. Apply Director of Nurses, The READING HOSPITAL, Reading, Pennsylvania.

TECHNICIAN—Qualified in both laboratory and X-ray for new 50-bed general hospital; 3 technicians employed; salary open. Apply MO 304, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; in beautiful new hospital located in progressive and interesting city, in smog free resort area; one hours drive from Los Angeles; laboratory under direction of full time pathologist; beginning salary $550.00 per month, plus very liberal fringe benefits. Write Administrator, ANTELOPE VALLEY HOSPITAL, Lancaster, California.

TECHNOLOGIST—One registered A.S.C.P. medical technologist for JCAH, 120-bed hospital, under the direction of a board pathologist; starting salary for new graduate $375.00, increased amount for technologist with a degree and for experienced technologist; attractive personnel policies. Apply Director of Personnel, DePAUL HOSPITAL, Cheyenne, Wyoming.

THERAPIST — Occupational; for 253-bed J.C.A.H. approved hospital; will serve medical-surgical patients, as well as those patients on our new 30-bed mental health unit; must have a degree; salary commensurate with qualifications. Contact Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

THERAPIST—Physical; qualified; 71-bed general hospital with excellent growth potential; salary commensurate with ability; five day week; four week paid vacation; twelve days sick leave annually and seven paid holidays. Write: stating references and salary desired to Personnel Director, KERBS MEMORIAL HOSPITAL, St. Albans, Vermont.

THERAPIST—Staff physical; willing to consider recent graduate; in and outpatient work; well equipped department; good starting salary. Write Assistant Administrator, MEMORIAL HOSPITAL, Casper, Wyoming.



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ADMINISTRATIVE POSTS—(h) Administrative assistant; hospital council: 40 member hospitals; salary open, about $7200; midwest. (i) Business manager with experience; excellent 5 doctor group, expanding; $7200 plus life and health insurance and other subsequent benefits; substantial raise, 6 months & thereafter; exceptional educational, recreational and housing facilities, Calif. (j) Purchasing director; 50 man group; own 325-bed research and teaching hospital; $8,000; east.

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ADMINISTRATORS — (a) Administrator; new 200-bed hospital under construction, suburb leading eastern city. (b) Administrator; new 75-bed well equipped hospital, New York. (c) Administrator; hospital expanding to 300-beds July; Florida. (d) Assistant administrator; 300-bed hospital, southwest oil center, $8000. (e) Director; Medical Education; develop program, Florida resorts, $18,000. (f) Woman assistant administrator; 400-bed hospital near New York City, $7000. MH6—1

ADMINISTRATIVE PERSONNEL — (a) Administrative assistant; credit collection in 500-bed hospital; will become assistant administrator; minimum starting $7000; near Pittsburgh. (b) Personnel director; hospital employs 1800; well integrated program, Ohio. (c) Business manager; southern California medical group; start $7500 plus; (d) Food Service Director; 500-bed private hospital, south, $8000 plus. (e) Public relations officer; organize, develop department; improve hospital efficiency; minimum start $7200, mid west. (f) Laundry manager, new 300-bed hospital, $5-7000. (g) Laboratory manager; 600-bed university hospital, east, $8000 up. MH 6-2

ANESTHETISTS—(a) Responsible for entire service, 100-bed hospital; resort area south, $9000. (b) Staff; 250-bed hospital industrial town near Detroit, average $8000. (c) Staff; days only; no weekends, Chicago, $6600. (d) Only one in department, small hospital near San Francisco, $6000 up. MH 6-3

(Continued on page 210)

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two new oxygen-tent units that are *easy to wash!*-

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Just remove door on top. Then wash the coils with hose or large volume of water!

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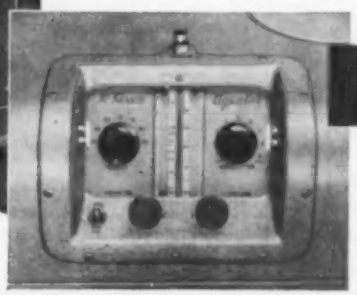
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100% HUMIDITY MAINTAINED BY THIS MODEL 1150!

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Velva-Sheen

with bactericide fights cross-infection by killing staphylococcus aureus where it dwells.

✓LABORATORY TESTED ✓HOSPITAL PROVEN

- Non-toxic, residual, non-selective
- Preserves effectiveness of conductive floors
- Classified SAFE as to fire and slip hazards by Underwriters Laboratories
- Beautifies and protects all hard surface floors

Now in use by hospitals, schools and institutions throughout the country.

FREE BROCHURE
SEND TODAY
No obligation

HOSPITAL Velva-Sheen is another market proven product manufactured by

MAJESTIC WAX CO.

the leader in Dust Control since 1925
1600 Wynkoop, Denver 2, Colorado.

Send brochure "HOW HOSPITAL Velva-Sheen Can Help Fight Cross Infection"

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TITLE_____
HOSPITAL_____
ADDRESS_____
CITY_____ ZONE____ STATE_____

MH-660

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIETITIANS—(a) Administrative; therapeutic dietitians, Australia, one year assignment; also Pacific Island opportunity. (b) Teaching dietitian; school of nursing near Chicago; $6600 and up. (c) Chief; 400-bed hospital; $7200 up. MH 6-4

DIRECTORS OF NURSING—(a) Director of Nursing; must be executive for complete nursing operation, service and education; large hospital and school; $10,000, east. (b) Director of nursing, school and service; 100 students; 200-bed hospital near Cape Cod; top salary. (c) Director of nursing; leading 350-bed hospital, 200 students NLN school; $8000, apartment, Lake Michigan university center. (d) Director of Nursing; new air-conditioned 250-bed hospital, 150 students; to $10,000; midwest. MH 6-5

EXECUTIVE HOUSEKEEPERS — (a) Chief; 350-bed hospital, Pennsylvania; $6000. (b) Chief; 300-bed hospital, commuting distance, New York City, top salary for outstanding man or woman. MH 6-6

MEDICAL RECORD LIBRARIANS—(a) Chief; 650-bed general, university affiliated hospital; excellent record committee; Great Lakes; $7500. (b) Head well organized department, 200-bed hospital, Chicago; $5-6000. (c) Consultant; 25 hospitals in established program, picturesque mountain states, west; excellent financial range. (d) Director; large hospital; challenging assignment; commuting distance, Nation's Capitol; $6-7500. MH 6-7

PLACEMENT BUREAUS

DOROTHEA BOWLBY ASSOCIATES

A Nation Wide Specialized Employment Service For Medical and Hospital Personnel
Dorothea Bowlby, Director
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Our service is for Men and Women. Administrators, Physicians, Personnel Directors, Business Managers, Purchasing Agents, Comptrollers, Plant Engineers, Public Relations Directors, Pharmacists, Dietitians, Food Service Directors, Physical Therapists, Occupational Therapists, Medical Record Librarians, Librarians, Anesthetists, Director Nurses, etc., Bacteriologists, Biochemists, Microbiologists, Virologists, Tissue Technicians. ALL INQUIRIES FROM APPLICANTS ARE KEPT STRICTLY CONFIDENTIAL.

(Continued on page 212)

FINEST FOR GENERAL SURGERY



BROWN MILLED
SURGEONS' GLOVES
by SEAMLESS

Brown Milled Surgeons' Gloves by Seamless are made of the finest Para rubber. They are gloves that cling to the hand and fingers . . . yet never grab with a tight grip. There's no loss of circulation, accelerated fatigue or loss of sensation. These are gloves acclaimed the world over for providing maximum sensitivity and maximum comfort compatible with long glove life. And hardly less important —their hypoallergenic properties minimize the possibility of contact dermatitis.
To give your surgeons the best, order SR-829. "Kolor-Sized" and Banded.

HOSPITAL DIVISION
THE SEAMLESS RUBBER COMPANY
NEW HAVEN 3, CONN.



Cat. No. 100-100 (illustrated), with 32 oz. irrigating bottle.
Cat. No. 100-102, without irrigating bottle.

improved model SKLAR electric evacuator

for Wangensteen Technique

The improved Sklar Electric Evacuator meets every demand for continuous, low grade suction and pressure. It may be regulated to meet the individual patient's requirements; thus, assuring maximum comfort and highly satisfactory clinical results. The Sklar Electric Evacuator is designed specifically for finely controlled, continuous suction and pressure in such procedures as: stomach evacuation, intestinal decompression, thoracic drainage, prostatectomy, gastric lavage, fistula drainage, and bladder irrigation. The versatility of this new model eliminates the need for highly specialized equipment. **No maintenance or lubrication required — guaranteed for two years.** Available through Sklar Surgical Supply Distributors. Send for descriptive literature and specifications.

A SKLAR PRODUCT

J. Sklar Manufacturing Co., 38-04 Woodside Avenue, Long Island City 4, New York

For additional information, use postcard facing back cover.

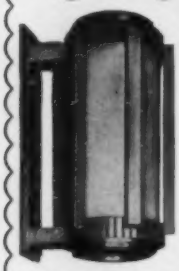


Bronze or Aluminum

Memorial Tablets

Desk and Door Plates
Signs • Donor Tablets
Add-a-Name Plaques
Portrait Tablets
Architectural Letters
in any size, for any purpose:
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Lighting Fixtures



of
Wrought Iron
Ornamental
Bronze
and Aluminum

Write for our profusely illustrated catalog, showing scores of designs, both simple and ornate. No job too small, none too large for personal attention.

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MARY A. JOHNSON ASSOCIATES
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We welcome inquiries for the many challenging opportunities we have for Administrators, Physicians, Nursing Executives, Medical Record Librarians, Dietitians, Laundry Managers, and all other Medical and Hospital Personnel who wish to relocate.

All negotiations strictly confidential.
No registration fee

INDIANA MEDICAL BUREAU
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Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

Information about
QUALIFIED NURSE PERSONNEL
is available from the
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SCHOOL-SPECIAL INSTRUCTION

The **CHICAGO LYING-IN HOSPITAL AND DISPENSARY** of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurses Anesthetists. Unlimited opportunities for endotracheal intubations open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan".

MT. CARMEL MERCY HOSPITAL offers an 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition $100.00 approved by the American Medical Association. For further information, write the Director of Laboratories, BARNES HOSPITAL, 600 S. Kingshighway, St. Louis 10, Missouri.

BARNES HOSPITAL: Offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Missouri.

LUTHERAN MEDICAL CENTER, 4520 Fourth Avenue, Brooklyn 20, New York. "School for Medical Record Librarians" Classes being formed now for September 1961.

The **PROVIDENCE LYING-IN HOSPITAL** offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.



Don't Mop Hospital Floors with Dollar Bills!

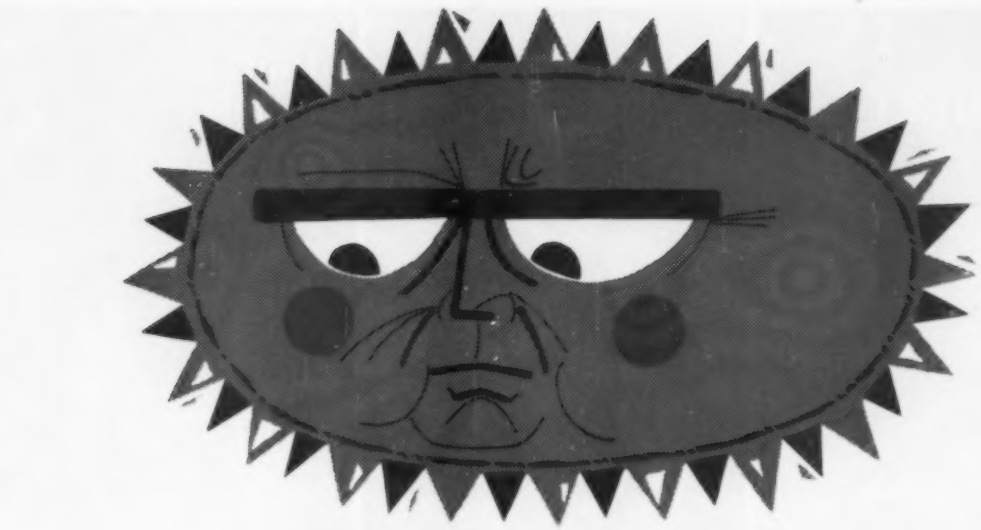
Save money—save time with flexible, efficient GEERPRES Mopping Outfits

If you're not using a GEERPRES mopping outfit, floor cleaning is probably costing you more than you think. Only GEERPRES has the design features and rugged construction to save costly labor time, give maximum service life.

Wringers give you powerful, uniform squeezing action—wring mops dry, quickly, easily, smoothly, in single operation. Patented design keeps splash and spray off cleaned floors. Electroplated wringers, galvanized buckets end rust—last for years. Mops last longer because wringers cannot twist, tear, tangle. Ask your jobber or write for catalog.

FLOOR-KING
MOPPING OUTFIT
FOR MOPS TO 36-OZ.

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WHY RUN OUT OF ICE?



CARRIER ICEMAKERS HAVE CERTIFIED CAPACITY

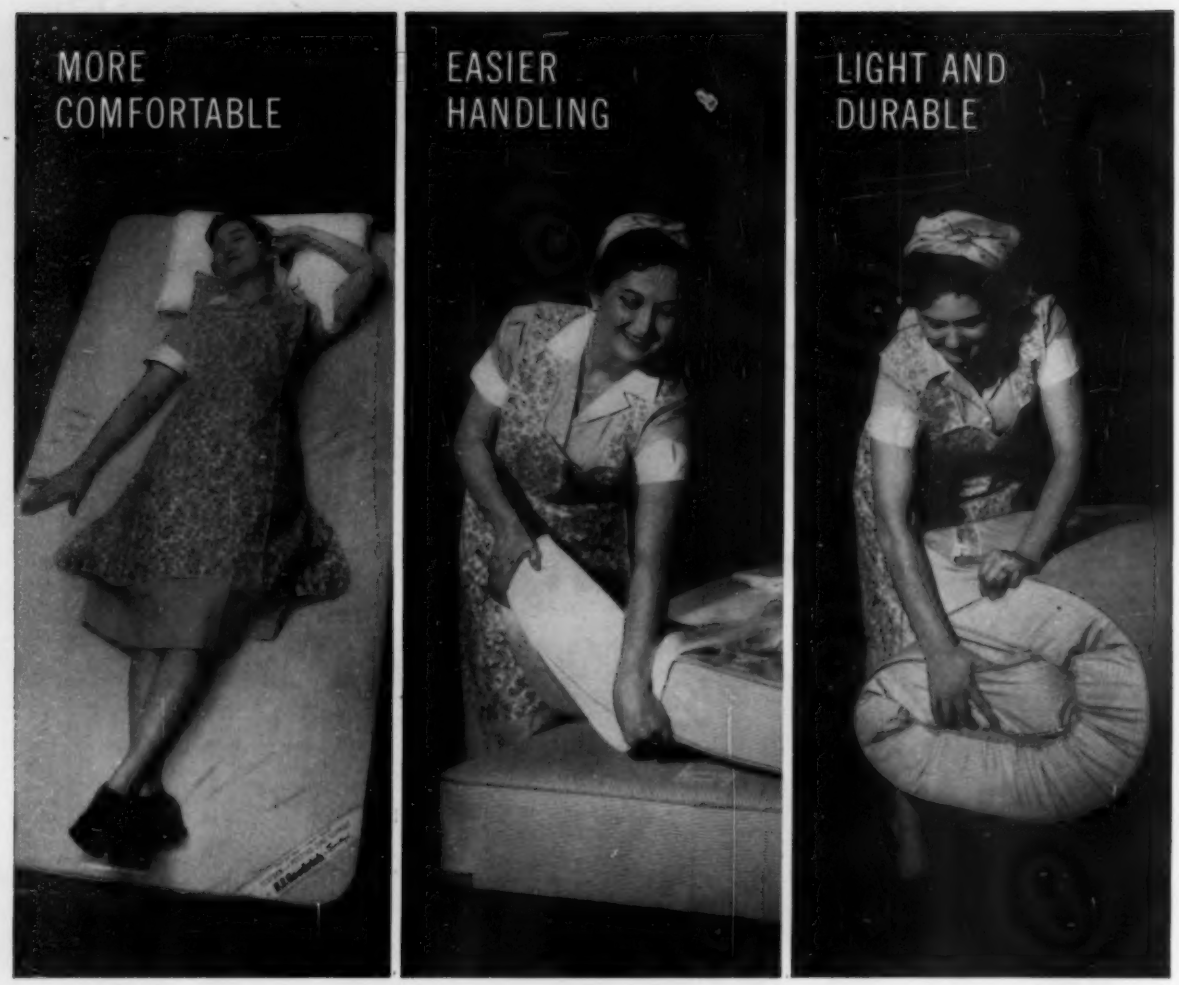
NO MORE GUESSING

Now you can have a truly dependable ice supply. Every Carrier ice machine is installed with its capacity certified in writing. There are no "up to" qualifications, no "average production" figures. The actual amount of ice you can expect is determined according to summer temperatures in your area, and backed by Carrier's certificate. Nobody else gives you this protection.

CUBES, CRUSHED, FLAKES OR CHIPS

There are 16 Carrier ice machines, giving you exactly the kind of ice you need. And besides getting the exclusive advantage of certified capacity, with a Carrier Icemaker you can save up to 80% on the actual cost of ice. For complete facts and figures, call your Carrier dealer, listed in the Yellow Pages under Ice Making Equipment. Or, write to Carrier Corporation, Syracuse 1, New York.

Carrier AIR CONDITIONING · REFRIGERATION



3 WAYS BETTER . . .
yet costs no more than a regular mattress

PUT a B.F.Goodrich Texfoam mattress on one bed and the mattress you are now using on another. Then have someone test them out—lie on the mattresses, change sheets on them, move the beds they're on, switch mattresses from one bed to another.

They'll prefer the B.F.Goodrich Texfoam mattress every time. Here's why:

B.F.Goodrich Texfoam is more comfortable because it's scientifically designed to give even support to the body's unequally distributed weight—there's no sag in the center where most of the weight is carried. To make sure you get correct rest, B.F.Goodrich *absolutely guarantees* never to ship or sell a "too soft" (low compression) mattress.

This B.F.Goodrich mattress is also easier to handle because it's lighter—20 pounds lighter than an ordinary mattress. Beds are easier to change, easier to clean around and under, easier to move when rooms are changed. It's tough, durable, too—can be folded, rolled, carried easily without splitting or creasing. And it's processed with Sanitized® hygienic bacteriostatic chemicals to help protect against staphylococcal infection.

Most important, this more comfortable, lighter, more sanitary mattress costs no more than any ordinary mattress of good quality. Why not get a BFG Texfoam and make the mixed mattress test. You have a choice of comfort-compression as well as that recommended by the U. S. Department of Commerce Standard 182-51. For complete information write, *The B.F.Goodrich Company, 119 Derby Place, Shelton, Connecticut.*

®T.M. Reg. U.S. Pat. Off.

TEXFOAM MATTRESSES BY B.F.Goodrich

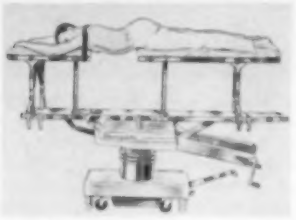
Edited by BESSIE COVERT

WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 241. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Operating Table Attachment Offers Surgeon Freedom of Hands

Offering the surgeon freedom of both hands, maximum vision and access to the heart at all times during surgical procedure, the S-1576-AM Maisel Heart Table Attachment is an assembly for surgery involving gravity exposure of the heart. Suited for supporting a patient in the prone position, it is especially convenient for surgery upon the rear portions or



vessels of the heart or for exposing the entire surface of the heart for treatment. **Shampaine Industries, 1920 S. Jefferson Ave., St. Louis 4, Mo.**

For more details circle #202 on mailing card.

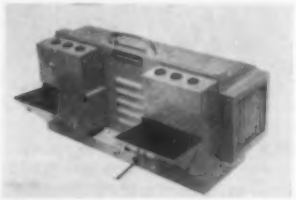
Unbreakable, Autoclavable Holder Protects Thermometers

Unbreakable, fully-autoclavable and economically priced, a new capped bedside thermometer holder and sterilizer of Zylonox plastic is designed to deliver maximum breakage protection and security. Features of the unit include a wide-flared base for tip resistance and a press-fit cap for positioning the thermometer, shielding it against air-borne contaminants and minimizing evaporation of sterilizing fluids. **Zylon Products Co., Inc., 40 Church St., Pawtucket, R. I.**

For more details circle #203 on mailing card.

Selectronair Purifier Filters Out Irritants

An electronic device, powerful enough to strain even the smallest bacteria and

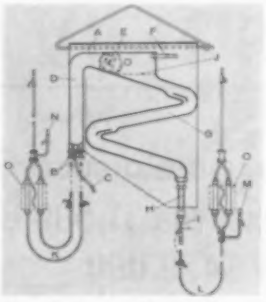


other irritating particles from the air, is available in the Selectronair. Disagreeable odors are also immediately dispersed in patients' rooms, kitchens, surgeries and other areas with the fast-working air purifier. The unit is particularly effective for use in rooms where patients have allergies, sinus congestion, asthma and the like as the industrial-type fans move the air at 120 cubic feet per minute, effecting fast results. The permanent, washable filters, one for each blower, effectively screen out particles and the germicidal ultraviolet lamps kill bacteria as the air passes over them. Easily adjusted dual vents control air flow as desired. The lightweight Selectronair unit is carried by its chromium plated handle and is easily placed in a window and connected, ready for use. **Selectronair, Inc., Shelton, Conn.**

For more details circle #204 on mailing card.

Perfuso-Pac Treatment for Mass Infections

Designed as part of the treatment of certain cancers and massive infections, "Perfuso-Pac" is a new device which permits localized treatment with huge doses of materials previously not used in such quantity because of possible damage to vital organs. The device serves as a small "heart-lung" for the portion of the body undergoing treatment. The technic, called



regional perfusion, is described as preventing deadly cancer-fighting agents from reaching critical areas of the body, including the central nervous system. The device is currently undergoing clinical testing and results will be evaluated as they develop. **Baxter Laboratories, Morton Grove, Ill.**

For more details circle #205 on mailing card.

Laundry Conveyor Carries Finished Garments

The National Bixler Conveyor for carrying garments through the laundry is completely redesigned. The dacron rope for holding hangers eliminates the time formerly required in waiting for carrying hooks. Effective for use wherever it is necessary or advisable to transport work on hangers, the conveyor can be arranged to stop garments at any selected point for processing or inspection. An elevating incline is an integral part of the conveyor where required, and garments can be automatically diverted off the conveyor onto a storage bar. The new design ensures more efficient operation, facilitates installation and lowers the cost. **The National Marking Machine Co., 4026 Cherry St., Cincinnati 23, Ohio.**

For more details circle #206 on mailing card.

Increased Economies and H.P. for Electric Power Producers



Emergency or general power producing units in the Caterpillar gas-operated line now have increased horsepower ratings. The G397 unit illustrated is improved to raise horsepower as much as 90 to a continuous rating of 560 h.p. The increased output is possible through turbocharging and aftercooling of the spark-ignition engines which operate on gaseous fuels. The new ratings, designed to provide additional economies in operation of these low-cost power producers, are built into all models in the gas-operated line, providing power at minimum cost. **Caterpillar Tractor Co., Peoria 8, Ill.**

For more details circle #207 on mailing card.

Lumex $100 Combination for Nursing Station

A special low price for a combination equipment "package" for the nursing station is offered by Lumex to hospitals and nursing homes. Included in the featured group of equipment are an all-new Formica nurses desk with matching uphol-



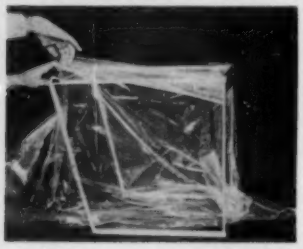
stered chair, and a Versacart Chart Cart with 20-chart capacity, all for $100. **Lumex, Inc., Valley Stream, N.Y.**

For more details circle #208 on mailing card.

(Continued on page 216)

Disposable Oxygen Tent Is Low Cost and Safe

The time taken to clean and cold sterilize oxygen tents, plus the possibility of



cross infection are eliminated with the new "One Time" disposable oxygen tent recently introduced. It saves labor, is made of heavy duty polyethylene, and fits all standard Mist O_2 Gen oxygen tent frames. The tent is sold at a price to permit it to be discarded after each use. **Mist O_2 Gen Equipment Co., 2711 Adeline, Oakland 7, Calif.**

For more details circle #209 on mailing card.

Verni-Trol Vaporizers for Kinet-O-Meter Gas Machines

Two new Verni-Trol Vaporizers for use with Ayerst Laboratories' Fluothane are introduced by Ohio for mounting on the Heidbrink Kinet-O-Meter gas machines. Epecially designed for the use, the new units operate on the same fundamental principle as the standard Verni-Trol. A separate control knob for the "Series 2000" or "piggy-back" model Kinet-O-Meter switches the circuit from the standard to the Fluothane Verni-Trol Vaporizer but utilizes the same circuit, flowmeters and flow control needle valves. The "side-arm" unit can be used with all models of the "Series 2000" and "3000" Kinet-O-Meters and has its own flow control circuit, separate flowmeter and control valve. **Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.**

For more details circle #210 on mailing card.



Proposed new wing for Mansfield General Hospital, Mansfield, Ohio.

WITH KETCHUM, INC. FUND-RAISING DIRECTION,

Mansfield General Hospital exceeds $1,500,000 building-fund goal by $429,000

Mansfield General Hospital is now breaking ground for a four-floor wing that will provide space for 125 more beds and supporting service facilities. When completed, the wing will make prompt, modern hospital care available to 5,000 more patients each year.

This extensive expansion program has been made possible by a successful capital funds campaign directed by Ketchum, Inc. Total pledges exceeded the $1,500,000 campaign goal by $429,000. After the campaign victory, Mr. Louis J. Ott, President of the Hospital Board of Trustees, said, "I want to express the thanks of the Board to your staff for the work they did, which was in all cases beyond the call of duty."

This is just one of many successful hospital campaigns directed by Ketchum, Inc. We will be happy to discuss *your* campaign plans at no obligation.

MEMBER AAFRC

Ketchum, Inc.

Direction of Fund-Raising Campaigns

CHAMBER OF COMMERCE BUILDING
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500 FIFTH AVENUE, NEW YORK 36, N.Y.
8 SOUTH DEARBORN STREET, CHICAGO 3, ILL.
JOHNSTON BUILDING, CHARLOTTE 2, N.C.

Encore Modular Furniture for Lounges and Waiting Rooms

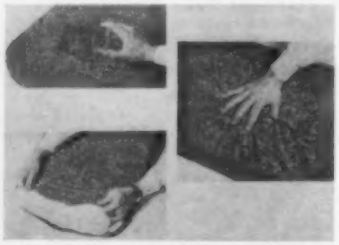


The attractive new Encore Metal Furniture offers modern attractive arrangements for lounges, waiting rooms, office areas and housing facilities. The modular design permits any desired arrangement of chairs and tables clamped together or free standing. All Encore seating units have seat and back formed from a one-piece welded channel of heavy gauge steel to which upholstery is applied, forming a strong non-breakable unit. All have wall saver design and solid walnut arms add to the attractive appearance. The square tube frames have Bronzite, Satin Chrome, White and Gold metal finishes, and a wide choice of upholstery covers and decorative plastic table tops is available. **The Howell Co., Div. of Acme Steel Co., St. Charles, Ill.**

For more details circle #211 on mailing card.

Nu-Foam and Rubber Mattresses For Any Size Cot

Soft and durable, Ferno mattresses of heavy density Nu-Foam do not deteriorate



or pack with age or heavy use and are made in two, three and four-inch thicknesses. Rubber mattresses of sponge latex with cored holes to lessen weight may be obtained in three and four-inch thicknesses. Available in lengths and widths to suit any cot, all mattresses are supplied with waterproof, wrinkle-free covers of rubber sheeting with full width zippers to permit fast removal for easy cleaning. **Ferno Mfg. Co., Greenfield, Ohio.**

For more details circle #212 on mailing card.

(Continued on page 218)



For the patient . . . maximum convenience
For the staff . . . minimum attention

with RCA VICTOR Hospital TV

with "Wireless Wizard" remote control



The Rosedale, Model 170-HTR-11. In handsome Ivory. Equipped with "Wireless Wizard" remote control for in-bed operation. 156 sq. in. viewable picture, 17-inch tube (overall diagonal).

• Installed as a permanent part of the room, or brought in on request, an RCA Victor Hospital TV set brings pleasure and relaxation to the patient. And RCA Victor's quality and dependability mean a minimum of attention.

With "Wireless Wizard" remote control, patients can change programs and turn off the set without leaving the bed or calling a nurse. A built-in volume limiter keeps sound from disturbing others. And, of course, the picture is bright and clear.

RCA Victor Hospital TV sets mean less work for your staff, too. "Tote-able" sets are easy to move . . . metal cabinets are easy to clean, are durable and resist liquid stains and burns. Every set is tamper-proof for maximum safety.

For the best possible reception, an RCA "Mastertenna®" can be easily installed.

It all adds up to why so many hospitals have turned to RCA Victor for their hospital TV needs . . . why RCA Victor is the most trusted name in television.

FOR COMPLETE INFORMATION SEND THE COUPON TODAY.

RCA Sales Corporation, Box 1226-A14, Philadelphia 5, Pa.
Please send me complete information on RCA Victor Hospital TV.

Name_____

Hospital_____

Street_____

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RCA VICTOR
Tmk(s)®
THE MOST TRUSTED NAME IN TELEVISION

New Mobile Unit Keeps Food Hot and Ready for Service



Food service is facilitated wherever an electrical outlet is available with the new Frick G 4 (KC) Special Hot Food Unit which keeps food hot and ready for service in areas away from the central kitchen. The unit, constructed with a stainless steel compartment and removable electric heating element, has a capacity of 54 ten-inch plates and covers, holds up to 700 pounds, and is available with chromium plated frame, drop push-pull handles, strip bumpers, super duty casters and other features. **W. H. Frick, 704 Citizens Bldg., Cleveland 14, Ohio.**

For more details circle #213 on mailing card.

Disposable Towelette for Diaper Changing Use

Baby Bottom Bath is the name given to the disposable towelette which provides a quick and convenient method of cleansing and soothing the skin when changing infants' diapers in the nursery. Designed to protect against skin rashes and to soothe sensitive areas while cleansing, the towelette contains benzalkonium chloride, an effecive antiseptic and deodorant, ethoxylan, a lanolin derivative, to form a protective coating on the skin, and menthol and ethyl alcohol five per cent for a cooling and soothing effect and rapid air-drying. Baby Bottom Bath is packaged in foil envelopes and is harmless should the baby get one and bring it into contact with its eyes or mouth. **Unexcelled Chemical Corp., Canaan, Conn.**



For more details circle #214 on mailing card.



Starlite and Driftwood Patterns In Forestone Acoustical Tile

Two new textures in Forestone fissured woodfiber acoustical tiles have been added to the Simpson line. Starlite is a star pattern textured in a soft-white, pre-finished acoustical surface and Driftwood imparts a casual, sand-etched appearance. Both patterns may be painted or tinted in any color without loss of pattern beauty or noticeable depreciation in sound-absorbing effectiveness. **Simpson Logging Co., 1033 White Bldg., Seattle 1, Wash.**

For more details circle #215 on mailing card.

Molded Cup Racks Save Weight, Space and Cost

Molded of Grex high density polyethylene, the new Cupsaver tray has handgrips molded into opposite sides for ease in handling, and is designed for use in conventional push-through, conveyor and peg-type dishwashing machines. It also fits on 20-inch square self-levelling dispensers and dishtables. The plastic is unaffected by boiling water and detergents, and is light in weight for ease in handling. It holds a maximum number of cups for space-saving in storage, is sanitary since it has no coating or crevices, and is economical in cost and use. **Raburn Products, Inc., 346 N. Clark St., Chicago 10.**



For more details circle #216 on mailing card.

(Continued on page 220)

NOW AT LAST HERE IS THE SOLUTION TO YOUR EGG PROBLEM

Nobody dreamed there *was* an egg problem until Economics Laboratory, in a continuing program of research achievement, revealed protein-type soils as the real villains in dishwashing . . . because they produce disabling foam which reduces wash pressure.

From this exclusive discovery it was then only a corollary for Economics Laboratory to develop Score* and Event*—the *only* new and different detergents that can *double* the efficiency of your present dishmachine operation by reducing foam. *PATENTS PENDING

First in performance through research leadership

ECONOMICS LABORATORY, INC.
250 Park Avenue, New York 17, N.Y.
Makers of Soilax and other fine cleaning products for home and institutional use.



I. V. Administration Set Is Disposable



Designed to fit American Sterilizer, Cutter and Fenwal solution flasks, the Sterilon CA-65 disposable I.V. administration set completes the Sterilon line. The company now makes disposable administration sets to fit any style solution bottle. All of the sets are disposable, leakproof, pyrogen-free, non-toxic and guaranteed sterile by the manufacturer. Each is fitted with the Sterilon Rolla-Valve Flow Regulator which permits instant adjustment of the flow rate of the solution being administered. **Sterilon Corp., 500 Northland Ave., Buffalo 11, N.Y.**

For more details circle #217 on mailing card.

Pulspirator Pump Oxygenator Eliminates Donor Blood Priming

A complete by-pass of the blood from the heart and lungs is permitted with the Pulspirator pump oxygenator, allowing procedures by direct vision in open-heart surgery. Primed with one liter of physiologic saline solution which remains in the oxygenator during the operation as a stratum above the blood, the new type of pump does not have to rely on fresh donor blood for priming. Low in cost and easily operated by oxygen from line pressure or cylinder, the Pulspirator requires no electricity and converts instantly to manual operation. **Foregger Co., Willis Ave. & High St., Roslyn Hts., L.I., N.Y.**



For more details circle #218 on mailing card.

One of the most economical luxuries you can provide:

DUNDEE TOWELS

They're super-soft, super-absorbent; make patients feel pampered. Yet Dundee Towels can stand up to rigorous institutional laundering week in, week out, because there's extra strength woven into every inch!

Your linen source can supply you with all these fine Dundee products: HUCK AND TURKISH TOWELS AND BATH MATS (both plain and name woven). CABINET TOWELING • FLANELETTES • DIAPERS • DAMASK TABLE TOPS AND NAPKINS • CORDED NAPKINS • DUN-FAST ALL-PURPOSE COTTON FABRICS



DUNDEE MILLS, INC.
SHOWROOMS:
1075 AVENUE OF THE AMERICAS
NEW YORK 18, N.Y.
MILLS AT GRIFFIN, GEORGIA

"Fabrique" Wall Covering Is Durable and Decorative

The durability and protection of vinyl and the decorative quality of fine wall paper are combined in "Fabrique," an economical, easily-maintained wall covering. "Fabrique" is scuffproof and virtually stainproof. Even lipstick, ball point ink or grease may be removed by wiping or lightly washing. It is a vinyl-impregnated non-woven fabric which is easily butted and will not shrink away from seams, baseboards or wainscoatings. **The Birge Co., Inc,. 390 Niagara St., Buffalo 5, N.Y.**

For more details circle #219 on mailing card.

Air°San Waste Receptacle Has Built-in Spray Sanitizer

Odor and bacteria are eliminated in the Air°San Waste Receptacle which has an individual Ozium sanitizing spray dispenser built into its cover. A pushbutton on the top permits a spray of Ozium to be sent into the receptacle to sanitize the interior and its contents. The patented Magi-Close features smooth, foot-operated opening and completely noiseless closing. The rustproof, Epon-coated liner, stainproof and impervious to most chemicals and alkalis, is easily removed for emptying. The streamlined receptacle is finished in white or Silvertone with chrome top. **Woodlets, Inc., 2048 Niagara St., Buffalo 7, N.Y.**



For more details circle #220 on mailing card.

(Continued on page 222)

confidence through experience

"Fluothane"—the most significant advance in inhalation anesthesia since the introduction of ether

NOW CONFIRMED IN HUNDREDS OF THOUSANDS OF CASES...OVER 200 PUBLISHED REPORTS TO DATE

"Fluothane" produces smooth, effective anesthesia . . . permits pleasant, rapid induction . . . allows rapid recovery and return to consciousness.

"Fluothane" does not increase bronchial, gastric, or salivary secretions. It minimizes capillary bleeding . . . causes minimal incidence of nausea and vomiting . . . and permits full use of electrocautery and x-ray during anesthesia because "Fluothane" is nonflammable, nonexplosive.

"FLUOTHANE"®

(BRAND OF HALOTHANE)

for precision inhalation anesthesia

Ayerst Laboratories • New York 16, N.Y. • Montreal, Canada

Ayerst Laboratories make "Fluothane" available in the United States by arrangement with Imperial Chemical Industries, Ltd.

5946

Two Multi-Purpose Slicers Introduced by Hobart

Two new food slicers are now offered in the Hobart line. Model 1612 and Model 1712 feature quick, uniform, crumb-free slicing, and adapt to multi-purpose use



through interchangeable food chutes and adjustable fences which permit random slicing of fruits, vegetables and meats. Both slicers have totally enclosed motors, neon lights to indicate motor operation, and are easy to clean and maintain. Model 1712 has a new high capacity for food slicing, accommodating even a 35-pound cooked roast. **The Hobart Mfg. Co., Troy, Ohio.**

For more details circle #221 on mailing card.

Disposable Hypo Needle in "Sterapac" Cartridge

A sterile disposable hypodermic needle, protected by a heat-sealed cartridge, is offered by Randall Faichney as the "Sharp-Et." The "Sterapac" cartridge is a polyethylene container with bacteriostatic properties which render the contents impervious to most bacterial and fungal attack, even after prolonged storage. An exclusive foil-seal guarantees the sterility of the needle. When the hexagonal cartridge, which fits snugly around the hub, is opened, the needle is ready for immediate use. The loaded syringe may be taken



from one area to another with the needle and cartridge attached for protection almost to point of contact. Needle gauge number is printed on the cartridge and the top is color coded for ready identification. **Randall Faichney Corp., 299 Marginal St., Boston 28, Mass.**

For more details circle #222 on mailing card.

Hospital Ward Desk Centralizes Charts

Chart recording and reading by doctors, nurses and technicians is simplified with the "Nurses' Charting Desk" which locates the charts of all patients at one point in a nursing area. A vertical chart holder revolves in the center of the unit and the desk provides space for eight persons to work at one time. The design permits use of the unit in conjunction with a small conference room near the nurses' station. Centered in an opening in the wall between the two rooms, the desk projects so that doctors can work on one side in their conference room with access to all charts in the holder without limiting their availability to nurses and technicians. Na-



tional Cylinder Gas Div., Chemetron Corp., 840 N. Michigan Ave., Chicago 11.

For more details circle #223 on mailing card.

Non-Slippery Polish Prevents Discoloring Floors

Developed especially to prevent discoloring or darkening of vinyl, asphalt tile, vinyl asbestos, linoleum, terrazzo and rubber tile floors, Contrast is a non-slippery, wax-free floor polish. It is self-shining and has a water base which will not discolor even white floors, according to report. Its tough, glossy finish resists black marks and scuffs and will not water spot, powder or flake, making it ideal for heavy traffic areas. **Huntington Laboratories, Inc., Huntington, Ind.**

For more details circle #224 on mailing card.

(Continued on page 225)



HM-801
FULL BODY IMMERSION TANK

"Figure 8" design permits all parts of the body to be reached from either side without entering tank. Twin Electric Turbine Ejectors provide double action hydromassage. Overhead hoist facilitates handling of non-ambulatory patients.

PB-110
PARAFFIN BATH
(for hand, wrist, elbow or foot)

Stainless steel, thermostatically controlled electric heating unit, dial thermometer. Removable stand.



ILLE:

A DISTINGUISHED NAME IN HYDRO- AND PHYSICAL THERAPY EQUIPMENT



MA-105
MOISTAIRE HEAT THERAPY UNIT

Delivers temperature-controlled moist heat safely and effectively. Complete with stainless steel treatment hood, table, latex foam table pad, nylon moistureproof curtains and 4-quart filling can.

SB-100
HUDGINS MOBILE SITZ BATH

For postoperative rectal or postpartum care of the perineal area. Sturdy stainless steel and aluminum construction. Optional maintenance electric heater.



ILLE ELECTRIC CORPORATION
Reach Road, Williamsport, Pa.



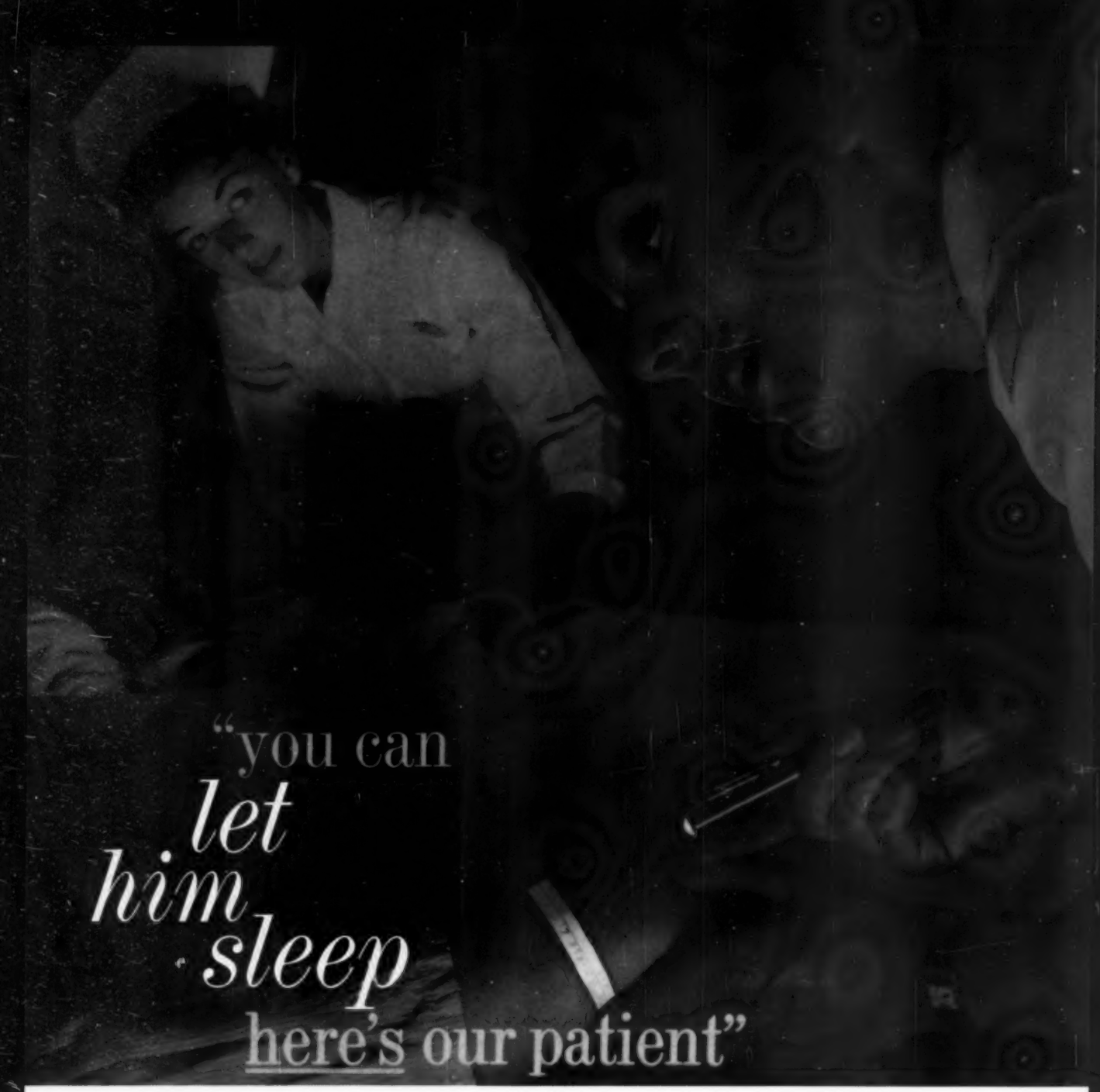
sealed

Ident-A-Band® has always offered sureness of identification, with the greatest comfort to your patients. Now, its finger-pressure Clip-Seal makes Ident-A-Band easier than ever to apply. Just press the clip and it's sealed—permanently sealed, with the important identifying information locked inside. The band itself is the same—skin-soft, slender for added comfort, safe in water, yet so tough it will not stretch off a wrist. It must be destroyed to be removed. That way you *know* it can't be put on someone else, either accidentally or on purpose. The Clip-Seal is easy. It's secure. And it comes only with Ident-A-Band, the proven way* to positively identify your patients. Evaluate Ident-A-Band and decide for yourself. Write

HOLLISTER®
INCORPORATED

*Over the past ten years, Ident-A-Band has been worn with safety and comfort by tens of millions of hospital patients. ®Registered trade-mark of Hollister, Inc.

833 N. Orleans St., Chicago 10—In Canada, Hollister Limited, 160 Bay St., Toronto 1



Hollister *Ident-A-Band*®

In the hospital hushed for night, nurses have a special job to do—see that patients get both their needed night care and their valuable sleep. In hospitals using Ident-A-Band by Hollister, there's no need to wake a patient to check identity, or risk a sleep-confused "yes" in answer to any name. Just a glance at the wrist and you're sure of correct identity before giving medications or care. Ident-A-Band helps keep disturbances (and tempers) down . . . your error-free record up.

Whether by day or at night, you can depend on Ident-A-Band to identify the right patient. And your patients will like its comfort. Only Ident-A-Band offers skin-soft identification that cannot be altered, water-blurred or transferred to another person. It's no wonder that more hospitals in the United States and Canada prefer Ident-A-Band . . . for nine years the leader in on-patient identification. Write for samples and complete information about Ident-A-Band.

HOLLISTER®

Hollister Incorporated, 833 North Orleans Street, Chicago 10, Illinois
In Canada, Hollister Limited, 160 Bay Street, Toronto 1, Ontario

Sterisnap Needle Pack Assures Sterile Technic

Special process plastic and moisture-resistant paper form the Sterisnap Pack for Tomac Sterile Hypodermic Needles. Designed to assure a sterile technic, the 20-chamber, tray-type container houses each needle individually in a separate sterile sleeve. The specially designed chamber lip breaks back to release one needle at a time, leaving the balance sealed and sterile. The stainless steel cannulas are precision sharpened for fast, effective veni-





puncture, and since chambers are shaped to support cannulas, the points do not touch the side. Packages are color-coded according to gauge for quick identification. **American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.**

For more details circle #225 on mailing card.

Baby Feeding Kits Contain Complete Assortment

Quality baby feeding kits are now available for infants leaving the hospital. Eight new kits are offered, providing necessities for every need. Basic in the kits are Even-flo nursers for safe and comfortable infant feeding, nipples, sterilizers, measuring spoons and other requirements for formula feeding. **Pyramid Rubber Co., Ravenna, Ohio.**

For more details circle #226 on mailing card.

Conserv-a-Matic File Operates Electrically

A development in automated filing to conserve time and effort is now available in Conserv-a-matic. Operating electrically and automatically, it eliminates bending, walking, stretching and pulling or pushing of file drawers. Pushbutton operation



brings the desired set of files within reach of the sitdown file clerk in an average of ten seconds, permitting quick access to or filing of material. Conserv-a-matic units are made of heavy gauge furniture steel in various heights and are equipped with 110 volt motors with plugs which fit any receptacle. Floor space is saved since the system permits use of full wall space to the ceiling. **Supreme Steel Equipment Co., 53rd St. & 1st Ave., Brooklyn 32, N.Y.**

For more details circle #227 on mailing card.

DuPont Fabrics Make Attractive Carpets

Carpets woven of patterned nylon, a newly developed form of "Orlon" acrylic fiber, and combinations of materials are introduced by DuPont and manufactured by established carpet makers. Patterned carpet is now available in nylon in a variety of colors and at modest price. The new staple carpet fiber developed by DuPont and marketed as "Orlon" virgin carpet acrylic is blended with wool, or with a modacrylic fiber and is woven, tufted or knitted to produce attractive, long wearing carpeting in a wide selection of patterns and colors. The highly durable new carpet materials are resistant to crushing and matting, have high cleanability and are



said to provide superior clarity of color with excellent fade resistance. **E. I. du Pont de Nemours & Co., Wilmington, Del.**

For more details circle #228 on mailing card.

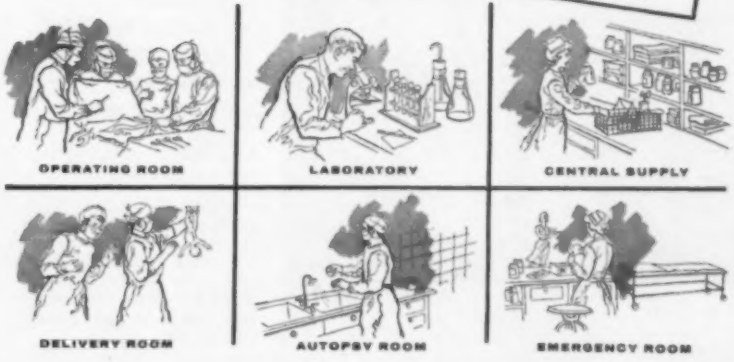
(Continued on page 226)

For cleaning all professional supplies
—metal, rubber, glass, plastic
—all through the hospital—
use WECK CLEANER. It's wonderful!



FREE Weck Cleaner is one of the Weck Specialties for the handling and processing of syringes, needles, catheters, instruments, etc., for Central Supply Service. Weck has prepared a special 8-page brochure which fully explains and illustrates this revolutionary new system. For your copy, just write to Weck.

Send for FREE sample of WECK Cleaner.



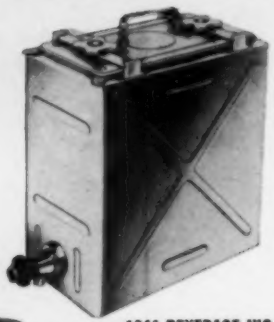
WECK EDWARD WECK & COMPANY Brooklyn 1, N.Y.
DIVISION OF STERLING PRECISION CORP.
70 years of knowing how
Manufacturers of Fine Surgical Instruments and Hospital Specialties · Instrument Repairing

LFC

STANLEY

STANLEY

STAINLESS STEEL VACUUM PRODUCTS



1341 BEVERAGE JUG — Holds 2 gallons. Stainless steel. 110 or 220 volts AC. Keeps constant 170°-188°F. No-drip shut-off.

THEY WILL NOT BREAK!

No wonder the finest hospitals, hotels, restaurants and institutions have specified STANLEY for over 35 years. Stainless steel construction of body and liner gives the utmost in thermal efficiency and saving on replacement.





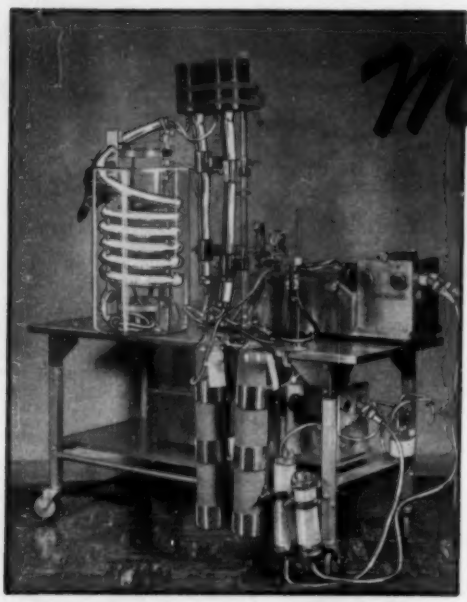


8396 BEVERAGE SERVER — Wide mouth, all-steel individual server for hot or cold liquids. Holds 10 ounces. Thumb-lift lid.

7320 STAINLESS STEEL PITCHER Holds 1 qt. Keeps liquids hot or cold. Steel liner never chips or breaks.

1353 INDIVIDUAL SERVING BOWL Stainless steel body and cover. For ice cream, soup, cereals. Easy to clean—no seams.

STANLEY THERMAL DIVISION
of Landers, Frary & Clark, New Britain, Conn.



MAYON Plastic Tubing shown on DeWall type bubble oxygenator as used by Dr. C. Waldon Lillehei and associates at the University of Minnesota for heart surgery.

Mayon

PURE VINYL SURGICAL TUBING

- ✱ NON-TOXIC
- ✱ CHEMICAL RESISTANT
- ✱ CLEAR—FLEXIBLE
- ✱ STERILIZABLE
- ✱ SMOOTH—INERT

Available from ⅛" to 2½" Internal Diameter.

Over 200 Universities, Hospitals, Foreign Medical Schools, Heart Clinics, and Veterans Hospitals have purchased MAYON plastic surgical tubing for use in heart surgery and general clinical use.

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415-17TH AVE. NO. • HOPKINS, MINN.
Phone: WEst 5-2187

Dish and Tray Lifters Speed Tray Set-Up

Shelleymatic elevators bring dishes and trays to convenient height in the Ideal Dish and Tray Lifters. When the top dish or tray is removed, another automatically moves to the service level position to speed tray



set-ups and other food service. Precision springs, protected from dust and dirt, serve as elevators and the desired level within the posts is reached by simply rotating the top adjustment ring. Ideal Lifters are filled by merely placing dishes and trays in position. The lifters are available with one, two or four stacks for all popular dish and standard tray sizes, either heated or non-heated, with or without rubber bumpers. Four swivel casters permit use of the lifters as mobile or stationary units. **Swartzbaugh Mfg. Co., Murfreesboro, Tenn.**

For more details circle #229 on mailing card.

New Pattern Offered in 11 Metallic Colors

The most recent addition to the B.F. Goodrich line of Koroseal vinyl upholstery materials is a lightly embossed pattern with a maze of irregular shapes resembling hieroglyphics. Called Pharoah, the new pattern is easily cleaned and is available in 11 metallic colors. **B.F. Goodrich Co., Marietta, Ohio.**

For more details circle #230 on mailing card.

Improved Challenger Machines for Floor Maintenance

A new size and improved design are announced for the Challenger line of floor maintenance machines. The 13-inch brush spread size is now available in addition to the 14, 16, 18 and 20-inch sizes. Quick



change attachments convert the improved machines from polishing to waxing, scrubbing, buffing, steel wooling and other floor maintenance operations. The quiet running heavy-duty capacitor motor creates no radio or electronic interference. The handle height can be adjusted by toe-touch of the locking clamp. The low motor height and chassis design permit cleaning under furniture. **Holt Mfg. Co., 669 20th St., Oakland 12, Calif.**

For more details circle #231 on mailing card.

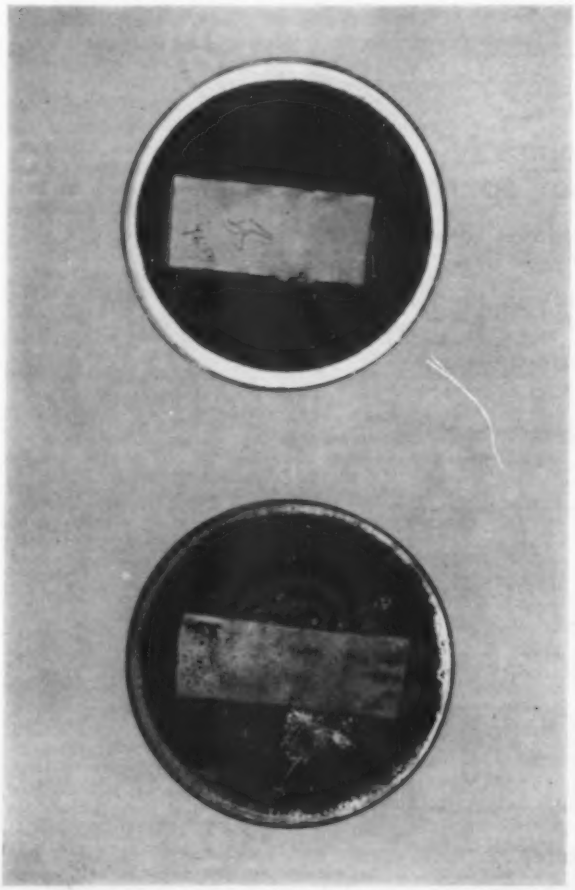
(Continued on page 228)

Which is your most sanitary window treatment?

Flexalum Twi-Nighter blinds are the most sanitary, and easiest-to-keep-sanitary window covering. Flexalum plastic tapes deter bacteria because there are no loose fibers or porous surfaces to absorb dirt as there are in fabric tapes. (See test below.) And Flexalum wipe-clean tapes won't fray, fade, stretch or shrink. Twi-Nighter blinds are made with a special nylon cord that has a harder, smoother, more sanitary surface than cotton cord. Flexalum's spring-tempered aluminum slats have a baked finish of enamel and emulsified wax that makes them exceptionally smooth and soil resistant. They won't rust, chip, crack or peel. You have the protection of a written five year guarantee by Bridgeport Brass Company.

Flexalum®

What's more, with Flexalum Twi-Nighters you can give your patients maximum range of light control — from soft diffused daylight to complete darkness. Write us today for free literature, or name of your nearest Flexalum dealer. He'll be glad to give you cost estimates at no obligation. Bridgeport Brass Company, Hunter Douglas Division, 30 Grand Street, Bridgeport 2, Connecticut.



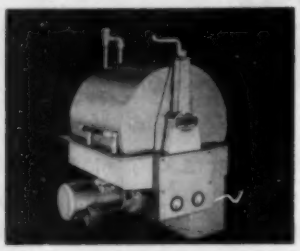
In Bacteria Test (directly above) fabric tape picked up over 700,000 bacteria per square inch. Flexalum wipe-clean plastic tape (top) picked up only 100 bacteria per square inch.* *Gar-Baker laboratory test.



Easy-to-clean Flexalum Twi-Nighter blinds give complete light control, let patients rest during even the brightest, sunniest days because they close tighter than ordinary blinds.

Counter-Type Dishwashers for Small Service Areas

Redesigned for more compact size and reduced space, the Blakeslee counter-type



dishwashers handle dishes for up to 50 persons per meal in minimum kitchen space. When equipped with automatically timed wash and rinse cycles, the A6 or AT6 save time by handling the dishes at the point of use for lunchrooms, snack bars or departments. Changes include a thermometer panel as part of the machine and a horizontal arrangement of the pump and motor which appreciably reduces the depth needed below the counter top for installation. **G. S. Blakeslee & Co., 1844 S. Laramie Ave., Chicago 50.**

For more details circle #232 on mailing card.

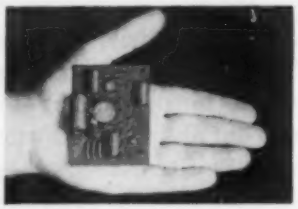
Pak-O-Meter Disposable Infusion Set

A completely disposable infusion set that is sterile and pyrogen free is offered in the Pak-O-Meter. The metering device accurately indicates flow at a glance and the simple Cam-Lock action monitors the flow with one setting. The metering unit is available in ranges for adult and pediatric application, is comparatively priced, and permits automatic I.V. feeding. **Galasyn, Inc., 2323 Huntington Drive, San Marino, Calif.**

For more details circle #233 on mailing card.

Executone Sound Systems Use Transistorized Pre-Amplifiers

Small transistorized pre-amplifiers are the heart of the new Executone sound



system which gives distortion-free reproduction of voice and music, even in large areas. One pre-amplifier is located adjacent to or built into every Executone microphone, radio tuner and record player in the system to boost the weak signal and make it strong enough to travel long distances to the power booster amplifier or mixer, without noise pick-up or other decrease in quality. Economies of installation and service are possible with the system and components of the new sound line are available in flush-mounted, surface-mounted or desk models to harmonize with the design of the institution. **Executone, Inc., 415 Lexington, New York 17.**

For more details circle #234 on mailing card.

SpeedClean Dry Vacuum for Complete Dry Clean-Up

Designed to perform complete dry maintenance clean-up in one trip, the new dry vacuum SpeedClean has all equipment for



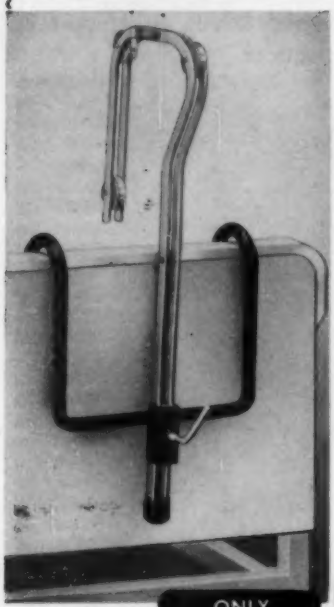
cleaning rugs, hard floors, walls and overhead trim with hose, wand and other accessories. The disposable filter dust bag at the rear of the machine is easily removed, and the large reusable refuse collection bags have draw strings at the top. A "Dust Mop Well" permits cleaning dust mops, dust cloths and the like without stirring or spreading dust. When used in washroom maintenance, the utility basket carries supplies of towels, soap, waxes and cleaning compounds. Speed Clean is available in four models. **Nobles Engineering & Mfg. Co., 645 E. Seventh St., St. Paul 6, Minn.**

For more details circle #235 on mailing card.

(Continued on page 230)

UNIVERSAL and REVERSIBLE BED HOOK

No. 208



EXCELLENT FOR SOLID HEAD AND FOOT BOARDS

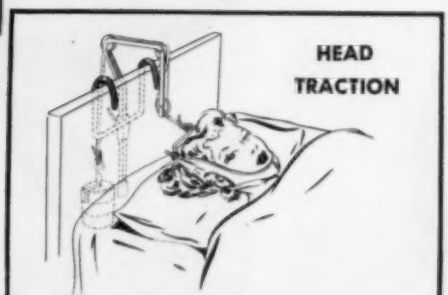
- Hook is 7/16" cold rolled steel, covered with tough no-mar plastic
- Fits over any type bed, including full panel . . . no holes to drill.
- Ideal for cervical and lower extremity traction including bi-lateral attachment.
- Vinyl tip is removable, for reversing hook

No. 208 Bed Hook Universal and Reversible

ONLY **$12.50** LIST



LOWER EXTREMITY TRACTION SET-UP . . . with bi-lateral attachment No. 208-BL, only $6.50 list.



HEAD TRACTION

Order from your surgical supply dealer.

OEC — **Orthopedic EQUIPMENT CO. BOURBON · INDIANA**

SPLINTS • FRACTURE EQUIPMENT • BONE INSTRUMENTS • SMO INTERNAL BONE APPLIANCES

EUROPEAN ASSOCIATES:
ZIMMER ORTHOPAEDIC, LTD., Bridgend, Glam, Great Britain • ORTOPEDIA G.m.b.H. KIEL, Kiel, Germany



These Little Rays of Sunshine Can Perk Up Appetites!

Here's psychology on a toothpick! DON cheerful "Eye-Catchers" stuck into the food add a touch of gayety to banish the gloom some patients have, especially at meal time. They lead to smiles — conversation — better appetites. Equally as effective on adults as on children. Add glamour to a tray — and good will toward your institution.

These cute little parasols, flags and other gadgets are among the many items shown in the new DON catalog.

Free assortment of samples; write Dept. 14 or ask your DON salesman about the "Eye-Catchers."

EDWARD DON & COMPANY
GENERAL HEADQUARTERS—2201 S. LaSalle St.—Chicago 16, Ill.
Branches in MIAMI • MINNEAPOLIS-ST. PAUL • PHILADELPHIA

CREST Heat-Pruf™ Faucet Washers LAST LONGER!

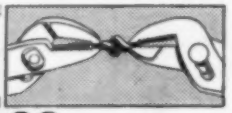


- **Independent laboratory tests prove it!**
- **Last from 2 to 10 times longer by actual test!**
- **Eliminate nuisance and high cost of washer replacement!**
- **One of thousands of dependable Crest plumbing maintenance products — attested by Master Plumbers!**

Try it yourself! **Rugged "Pliers Test" proves tough Crest washers can really take it. Severe torture tests will not harm Crest washers.**



FREE CATALOG



Write today for complete 200-page Crest Catalog illustrating over 3,000 Quality Plumbing and Heating Maintenance Specialties.

Gentlemen: At no obligation, please send me a FREE copy of the new Crest Catalog.

Name_____ **Title**_____

Company or Institution_____

Address_____

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CREST MANUFACTURING COMPANY
455 [illegible] Avenue, Long Island City 1, New York



A *Life* may depend on your floors

In the operating room where so many lives have been saved, dangerous static currents are always lurking.

Your conductive flooring can protect you against electric shock, fire or explosion *only if it is properly maintained.* And only LEGGE polishes, cleaners and seals are specifically designed to retain the conductivity of your floors.

Recommended by Leading manufacturers

LEGGE maintenance materials insure the safe dispersion of static charges into your floors. That's why Congoleum-Nairn, Hubbellite and other makers of conductive flooring recommend their *exclusive* use.

Your purchase of these products entitles you to the Free services of a LEGGE Safety Specialist, trained to aid you in every phase of conductive floor maintenance.

For Safety's sake, mail the coupon or write for our descriptive brochure, "One Little Spark."

See our insert in Hospital Purchasing File.

Walter G. LEGGE Company, Inc.
Dept. MH-6, 101 Park Ave., New York 17, N. Y.
Branch offices in principal cities.
In Toronto — J. W. Turner Co.

Please rush your brochure on Maintenance of Conductive Floors.

Name_____

Hospital_____

Address_____

City_____ **Zone**_____ **State**_____

Indexing Kit For Microfilm Records

A new indexing kit, complete with instruction booklet, provides an easy step-by-step method for finger-tip accessibility of records on microfilm. For use with nearly any type of microfilmer, the kit includes flash cards, targets and other forms for proper organization of the material on film. **Recordak Corp., 415 Madison Ave., New York 17.**



For more details circle #236 on mailing card.

Disposable Luer-Lock Needles Have Hypolance Points

Stainless steel canulas, brass-nickel plated hubs and the new Hypolance points are features of the Hypostainless Disposable Luer-Lock Needles which are packaged sterile, pyrogen-free and ready for immediate use. Every clear-front packet is sized-coded for easy handling and access, and the disposable needle is available in almost every hypodermic size. The one-time use of the needle eliminates the problem of cleaning and sterilizing and the possibility of cross infection. **Hypo Surgical Supply Corp., 11 Mercer St., New York 13.**

For more details circle #237 on mailing card.

Space and Noise Problem Solved With Foldoor Soundguard

A fabric-covered folding partition, with effective insulation and perimeter sealing around jambs and operating edges, closes out sound while separating space. The Foldoor Soundguard is ruggedly constructed, easy to maintain, and makes an attractive wall when used to divide large rooms or other areas. The draw latch on high doors is released by a natural downward pull, facilitating handling and avoiding delay in case of emergency. **Holcomb & Hoke Mfg. Co., Inc., Dept. 1232, 1545 Van Buren St., Indianapolis 7, Ind.**



For more details circle #238 on mailing card.

Cleaner-Disinfectant for Toilet Bowl Sanitation

Safety and efficiency in use are assured with the new formulation, packaging and dispensing of First Glo-Bol, a toilet bowl cleaner-disinfectant. Packed in a one-application, transparent film package which, when dropped unopened into the toilet bowl, dissolves in seconds to release the Glo-Bol granules into the water, the product eliminates the possibility of breakage and spillage and of exposure to personnel through actual handling. The cleansing foam rises above the water line to dissolve the ring of mineral deposits left by evaporation and produces high detergency with odorless disinfection. Soil is carried away with bacteria to leave the bowl sanitized. The prepackaged portion control eliminates measuring and handling and assures proper chemical activity and cleaning. **Piatt & Smillie Chemicals, Inc., 3419 Gratiot St., St. Louis 3, Mo.**



For more details circle #239 on mailing card.

(Continued on page 232)

HERE'S MORE *DEPENDABILITY* and *EFFICIENCY*...



FOR YOUR HOSPITAL!

DEPENDABLE **"AG"** *Bovie*

Choice of surgeons the world over! Automatic spark gap adjustment and independent cutting currents are typical of its many features.

In all forms of electrosurgery—general, neuro, gynecologic, urologic, neoplastic, proctologic, thoracic and EENT—surgeons count on the "AG" Bovie for precision, range and flexibility.

EFFICIENT **L-F BASALMETER®**



Now your hospital can give BMR tests faster, more easily, more accurately. Here is the modern way to administer basal metabolism tests—set the factors, connect patient to system, release oxygen, *press a button* and read the BMR direct from a large meter. No charts, graphs, slide-rules or computations.

The BasalMeteR saves time, eliminates errors in computations, makes your hospital's BMR testing much simpler.

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Medical Division

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HOSPITAL.....
ADDRESS.....
CITY.....ZONE.....STATE.....



BURROUGHS HOSPITAL ACCOUNTING MACHINES REDUCE COSTS, PROVIDE COMPLETE CONTROL OF PATIENT ACCOUNTS

The scene: Expanding Greenville General Hospital, Greenville, S. C. **The job:** Accounting records of 25,000 in-patients and 100,000 out-patients annually. **The equipment:** Burroughs Series F Accounting Machines. **The results,** in the words of Director Robert E. Toomey: "Burroughs Accounting Machines chosen largely on the basis of our satisfaction with other Burroughs equipment throughout the hospital greatly facilitate our 'Columnar Plan' accounting. Together, the plan and the equipment have increased speed and accuracy, drastically cut direct operating costs, and given us complete control of patient records." Burroughs—TM



Director
Robert E. Toomey

Greenville General Hospital is one of many hospitals helped to new accounting efficiency by Burroughs office automation equipment. For details, ask to see our informative film, "Data for Diagnosis." Call our nearby branch now. Or write Burroughs Corporation, Detroit 32, Mich.

Burroughs Corporation

"NEW DIMENSIONS / in electronics and data processing systems"

Pneumatic Equipment Relay for "Fail-Safe" Operation

Protection in case of air line failure of pneumatically controlled air conditioning, heating and ventilating systems is afforded with the compact new Type 783 reverse relay developed by Powers Regulator. The auxiliary device gradually reverses the action of pneumatic-operated valves, motors and dampers, converting normally-closed pneumatic equipment to normally-opened operation and vice versa. It is small enough to mount easily on a valve or damper motor, behind control panels or next to a wall-mounted instrument. **The Powers Regulator Co., 3423 Oakton St., Skokie, Ill.**

For more details circle #240 on mailing card.



Metabolism and Pulmonary Function Tested Using Room Air

No oxygen tanks or capsules are required with the new Combination Metabolism and Pulmonary Function Testing Unit, which uses only room air for either type of testing, allowing the patient to breathe at ease in his own accustomed atmosphere. Dependable BMR results according to the individual requirements of each patient are assured with variable volumes and timer speeds and the unit is readily altered to pulmonary function testing without the complication of valves. Permanent proof of a valid test is provided with inkless tracing sheets which indicate the difference between oxygen consumption and occurrence of a leak. **Jones Metabolism Equipment Co., 315 S. Honore St., Chicago 12.**

For more details circle #241 on mailing card.

Conductive Nylon Restraint May Be Used in Surgery

Metallic strands are interwoven into the new Duxe "Gold Stripe" Restraint, providing a positive conductive path for static



dissipation. All-aluminum and stainless steel buckles prevent rust or corrosion to ensure conductivity. The nylon restraint is available in one or two piece styles, for all stretcher or operating table uses. The one piece restraint is six feet long and the two piece is five feet, exclusive of fastening loops. **Duxe Products, 205 Keith Bldg., Cincinnati 2, Ohio.**

For more details circle #242 on mailing card.

Kol Waste Kollector Now in Eight-Bushel Size

An eight-bushel capacity Kollector is now available in the line of Kol mobile waste collectors. The new extra large size supplements the four and six-bushel units previously available and permits choice of the most efficient unit for the need. Kollectors fold for storage with bag attached or removed and the frame is engineered not to tip. Bags are sturdy, with double seams, double top and triple reinforced grommets, and are available in durable white twill, duck or Sanforized blue denim.



Three-inch swivel rubber-tired casters make the Kollectors easy to handle. **Kol, Inc., 2323 Ellis Ave., St. Paul 14, Minn.**

For more details circle #243 on mailing card.

(Continued on page 234)



Bally **walk-ins**

Aluminum or steel sectional construction

Sanitary! Strong! Efficient! You can assemble any size cooler, freezer or combination in any shape from standard sections. Add sections to increase size as your requirements grow. Easy to disassemble for relocation.

Bally Case and Cooler, Inc., Bally, Pa.

Get details — write MH-6 for FREE book.

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Wall-Saving Easy Chair
Rubber cushions and platform
Size scaled to small room use

Wide assortment of chairs and tables. See your dealer or write us for our distributor's name.

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You're a hospital administrator ...not a laundry specialist!

As many hospital administrators will tell you—handling your own laundry is horse and buggy management.

It creates needless overhead—the purchase and replacement of linens . . . extra laundry personnel... extra supplies... extra, expensive equipment... extra maintenance. And don't forget that laundering space could be turned into room for extra beds.

Your local Linen Supplier can furnish every cotton cloth item your hospital requires—sheets, pillowcases, towels, gowns, uniforms, etc. He will launder them *hygienically*, maintain your inventory for you and keep you supplied on a schedule that suits your needs. And, of course, you pay only for what you use.

Make that call to your Linen Supplier now. Find out how Linen Supply can cut your overhead . . . improve efficiency.



Look in the Yellow Pages under "Linen Supply" or "Towel Supply."

Note: No investment, no maintenance, no inventory. Everything is furnished and serviced by your local linen supplier, at low cost.

Linen Supply Association of America
and National Cotton Council • 22 West Monroe Street, Chicago 3, Illinois

Dorsette Institutional Tissue Is Two-Ply Facial Quality

A new two-ply facial quality institutional tissue is available in Marathon Dorsette. It



has a smooth, soft, white surface with a fast rate of absorbency. Rolls of 500 two-ply or 1000 single-ply four and one-half-inch square sheets are supplied in shipping cases especially designed to be used as waste receptacles when empty. **Marathon, Div. of American Can Co., Menasha, Wis.**

For more details circle #244 on mailing card.

Linear Count Ratemeter Measures Varying Rate of Flow

Blood Circulation or any other function characterized by a varying flow rate is effectively measured with the Model CRM-11A linear count ratemeter. Diffusion of injected radioactive material is traced and measured precisely using a G-M, scintillation or proportional counter detector. Six counting ranges and five time constants are selected by panel control and a connector is provided for a graphic recorder. Designed for trouble-free operation, the unit features a circuit so stable that no zero control is needed, a separate high voltage meter to simplify operation, and other advantages. **Nuclear Measurements Corp., 2460 N. Arlington Ave., Indianapolis 18, Ind.**

For more details circle #245 on mailing card.

Opaque 1000 Delineascope Offered in Two Models

Two basic models are offered in the all new AO Spencer Opaque 1000 Delinea-



scope. Adjustments and controls are on the right hand side of the instrument for easy operation. Convenience is also provided with the new optical pointer and locking platen. The superior quality coated projection objective and all-glass reflecting system combine with a 1000-watt bulb to produce maximum light on the screen for a sharp projected image. The instrument remains cool through the efficient cooling system which also protects copy. **American Optical Co., Instrument Div., Buffalo 15, N.Y.**

For more details circle #246 on mailing card.

"Swivel-Action" Sign Frames Resist Damage

Wall-mounted signs that can take bumps without damage are available in the new Milligan "Swivel-Action" Sign Frames. Attractive in appearance and easy to install, the frame is fastened to the swivel mounting bracket in such a way that if it is struck



it merely folds back toward the wall. It is then easily returned to its original position undamaged. Transparent vinyl is used for the signs, thus eliminating breakage. Frames are made of heavy, non-rusting, polished extruded aluminum with stainless steel fasteners. The signs are available in six models in sizes to meet all requirements. **Milligan Corp., P.O. Box 10615, Pittsburgh 35, Pa.**

For more details circle #247 on mailing card.

(Continued on page 236)

Here's Proof!

Hospital-Approved PURAPHEN®

is the Most Effective Cleaner-Germicide You Can Use

(Phenol Coefficient 10 FDA)

Check List of PURAPHEN Proved Performance

Germicidal & Fungicidal	YES	Effective Against Escherichia coli (urinary tract infections)	YES
Effective in any Degree of Water Hardness	YES	Effective Against Salmonella choleraesuis (food-poisoning outbreaks)	YES
Effective Under any Soil Condition	YES	Effective Against Virulent Tubercle Bacilli (Tuberculosis infection)	YES
Effective Under Acid or Alkaline Conditions	YES	As a Fungicide, Effective Against Trichophyton interdigitale ("Athlete's Foot")	YES
Approved for use on Conductive Flooring	YES	Microsporum gypseum ("Ring Worm" of skin and scalp)	YES
Affected adversely by Organic Matter (Blood, Serum, Soap, etc.)	NO	Epidermophyton floccosum ("Athlete's Foot")	YES
Effective Against Pyogenic and Enteric Bacteria	YES	Candida albican's (foot, mouth and vaginal infections)	YES
Effective Against Salmonella typhosa (typhoid bacillus)	YES	Effective as a Bacterial Sporicide against spores of Bacillus subtilus and Clostridum tetani (tetanus bacillus)	YES
Effective Against Staphylococcus aureus (staph infections—abscesses, boils, pimples)	YES	Hospital Approved	YES
Effective Against Streptococcus fecalis ("strep" infections)	YES	Approved by American Hotel Association	YES
Effective Against Pseudomonas aeruginosa (Bacillus of green pus)	YES	Approved by Rubber Manufacturers' Association	YES
Effective Against Proteus vulgaris (Ear and chronic infections)	YES	Complies with Asphalt Tile Institute Requirements	YES

Puraphon is advertised in Modern Hospital, Hospitals, Hospital Management and Hospital Progress magazines.



MAIL THIS COUPON for complete PURAPHEN data and independent laboratory's verifications.

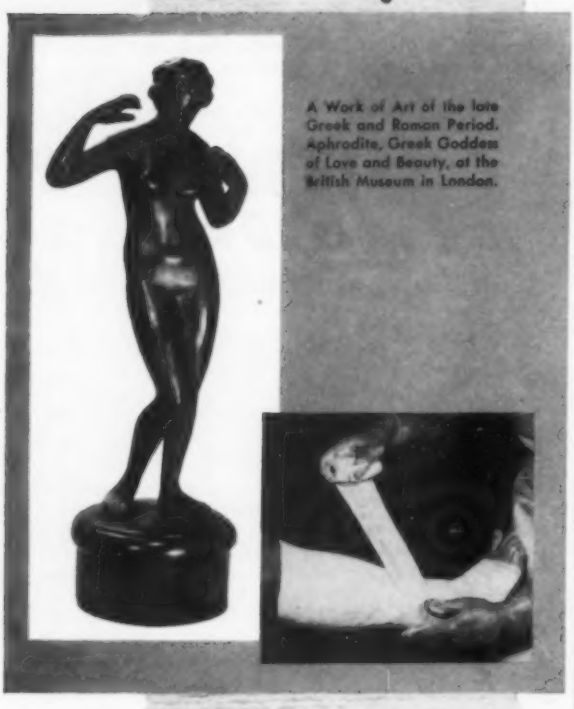
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PECK'S PRODUCTS CO. 610 E. CLARENCE ST. LOUIS 15, MO.

A Work of Art



A Work of Art of the late Greek and Roman Period. Aphrodite, Greek Goddess of Love and Beauty, at the British Museum in London.

With STUCCA Plaster of Paris bandage you create a work of art . . . a perfect cast . . . with speed, strength, fidelity – assuring firm support and immobilization for every type of fracture, every time.

STUCCA's creamy, consistently smooth plaster is easily applied, conforms precisely to body contours and, when dry, can take heavy abuse – so important with active children! And it's lightweight, too.

STUCCA's great final strength means you can construct lighter casts thus providing greater patient comfort and reduced X-ray exposure time.

Extra-fast setting time, 2-4 minutes. Or, you can control the setting speed yourself.



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Hanovia Equipment

LUXOR ALPINE QUARTZ LAMP



Delivers complete ultraviolet spectrum. Provides intense radiation of wide, even distribution.

SUPER ALPINE QUARTZ LAMP



Powerful, high intensity quartz mercury arc emits all effective intense bands of therapeutic ultraviolet.

AERO-KROMAYER QUARTZ LAMP



Intense, concentrated source of ultraviolet for local and orificial application. Air cooled!

proving high clinical value

of ultraviolet therapy in treatment of all these diseases and conditions:

Physical Rehabilitation: Ultraviolet is particularly effective in increasing blood hemoglobin level. Authoritative report reads: "The blood changes produced by ultraviolet radiation are increased number of red and white cells and platelets, lowered blood sugar, increased sugar tolerance, increased blood calcium, relative lymphocytosis and eosiniphilia." Other authorities state: "Ultraviolet exerts a glycogen storing effect preventing the lowering of respiratory quotients after muscular exercise." Exposure to Hanovia ultraviolet improves absorption and utilization of calcium, iron, nitrogen and phosphorus.

Tuberculosis: Irradiation is of distinct value for patients suffering from tuberculosis of the bones, articulations, peritoneum, intestine, larynx, and lymph nodes, or from tuberculosis sinuses.

Care of Infants and Children: The prophylactic and curative effects of ultraviolet radiation on rickets, infantile tetany or spasmophilia, and osteomalacia are well known.

Psoriasis: Goeckerman technique, crude tar and ultraviolet radiation, very helpful in numerous cases. Ultraviolet produces definite chemical change in tar, a combination both reliable and effective.

Other applications *include* treatment of numerous skin diseases, with ultraviolet radiation acting specifically on lupus vulgaris, and providing a beneficial effect in such conditions as acne vulgaris, pityriasis rosea, indolent ulcers, and some forms of eczema.

Yours on request: Authoritative treatises describing ultraviolet therapy. Write for your free copies today. Dept. MH-4.

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For additional information, use postcard facing back cover.

Pharmaceuticals

Lipitest Reagent

A quick determination of total serum lipids can be made with the new Lipitest Reagent (Schain). Requiring only three minutes of working time and 30 minutes for analysis, the product is supplied in 500 cc. bottles, or 500 cc. bottle and kit including two Lipitest bottles. **Merck & Co., Inc., Rahway, N.J.**

For more details circle #248 on mailing card.

Syndecon

A combined medication containing improved penicillin made synthetically, Syndecon is designed for use in combatting upper respiratory infections accompanying colds and influenza. It contains, in addition to Syncillin, a pain-relieving drug and Naldecon to promote sinus drainage and relieve nasal discomfort. Syndecon is supplied in tablet form and as a soluble powder for oral administration. **Bristol Laboratories, 630 Fifth Ave., New York 20.**

For more details circle #249 on mailing card.

Motilyn

Motilyn, a pantothenic acid derivative, is a new injectable product for restoring intestinal function in cases of ileus, enteric atony or delayed motility following surgery. It may also be used prophylactically. Motilyn is supplied in 2-ml ampoules containing 500 mg. and in 10-ml. multiple-dose vials. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #250 on mailing card.

Chemipen

Squibb Phenethicillin Potassium, a chemically improved penicillin, is released as Chemipen. It is supplied in tablet and syrup form, for oral administration. The chemically modified penicillin produces and maintains high blood levels with greater speed than natural penicillin. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #251 on mailing card.

Elipten

Elipten is a new anticonvulsant which controls seizures in most forms of epilepsy. It is effective in refractory cases, especially when combined with other anticonvulsants, often reducing dosage requirements of the latter. Other medications can be completely eliminated in some cases, improving alertness and sociability. Elipten is supplied in 250 mg. white scored tablets in bottles of 100. **Ciba Pharmaceutical Products Inc., Summit, N.J.**

For more details circle #252 on mailing card.

Delenar

Combining low-dosage dexamethasone, the muscle-relaxant action of orphenadrine and aspirin, and an "inherently buffered" neutral form of aspirin, Delenar provides comprehensive therapy for treatment of the inflammation, muscle spasm and pain of mild or moderate rheumatism, arthritis and injuries affecting joints, tendons and soft tissues. It is packaged in bottles of 100 and 1000. **Schering Corp., 96 Orange St., Bloomfield, N.J.**

For more details circle #253 on mailing card.

Literature and Services

• A 12-page **instruction booklet**, entitled "**How to Bend Conduit**," furnishes instructions for making precision bends in electrical metallic tubing and rigid steel and aluminum conduit, and particulars on the five chief fundamental bends. Containing diagrams, offset formulas and shrink and "gain" tables, the brochure, prescribed for both the standard and "Powr-Jack" type benders, is available from Appleton Electric Co., 1701 Wellington Ave., Chicago 13.

For more details circle #254 on mailing card.

• **Catalog No. 100-H** contains specifications and photographs of the complete Lyon line of steel equipment for schools, colleges, hospitals and other institutions. The 92-page general catalog released by Lyon Metal Products, Inc., Aurora, Ill., includes several new products which are illustrated for the first time.

For more details circle #255 on mailing card.

• The complete Spring Air line of mattresses is shown in the "**Spring Air Sleep Products Institutional Catalog**" of special interest to hospitals and similar institutions. Three innerspring and two foam rubber mattresses in varying price ranges are described as is the special washable plasticized ticking which is waterproof and resistant to rot. The new catalog can be obtained from the Spring Air Co., 666 Lake Shore Dr., Chicago 11.

For more details circle #256 on mailing card.

(Continued on page 238)

NEW

PULMONARY FUNCTION EQUIPMENT BY COLLINS

- **TREADMILL**
- **KROGH SPIROMETERS**
- **PLETHYSMOGRAPHS**
- **ANIMAL SPIROMETERS**
- **BLOOD TONOMETERS**
- **NEW HIGH VELOCITY LOW RESISTANCE VALVES**
- **NEW COLLINS HELIUM RESIDUAL VOLUME UNIT**

These latest additions to our steadily increasing line of Pulmonary Function Equipment and accessories are now being produced because of the many requests for these items.

A new catalog is now available describing this equipment. Just drop us a line indicating your preference and we will send it to you. Ask for catalog H-6.

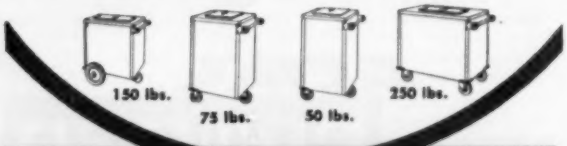
WARREN E. COLLINS, INC.

555 HUNTINGTON AVENUE BOSTON 15, MASSACHUSETTS



Gennett at Duluth Model 75

St. Mary's Hospital, Duluth, Minnesota, has purchased a total of twenty-one *Gennett* Ice Carts for the purpose of distributing ice to the various nursing stations and sections of the Hospital. Dec. 23, 1959, they wrote: "The Carts have been used approximately one year now and we find them very satisfactory". Write GENNETT AND SONS INC., One Main Street, Richmond, Indiana, for counsel on *your* ice distribution problems.



GENNETT Ice Carts



New
Latter-day Saints Hospital
Salt Lake City,
Utah

OLSON Mechanized Food Handling System

Moves 1500 Meals a Day... fast quiet safe



▲ LDS Hospital kitchen staff totals 75 . . . prepares and serves an average of 1500 patient meals a day using two Olson Conveyors and "assembly line" tray make-up. Dietitian at end of each line checks trays as they glide up on way to all floors above.



Near split-second timing for every tray . . . ascending Olson Subveyors pick them up safely, automatically from kitchen Conveyors. Serving floor attendants deliver trays to bedsides. Patients enjoy hot, appetizing meals within a few minutes after tray make-up.

An Olson mechanized food and dish handling system pays for itself in short order because . . . *it enables fewer people to serve more meals in less time.* It's the only way your dietary department can have fool-proof control of every meal—every tray—on an exact schedule. And Olson systems are simply-designed for cleaning ease, beauty, durability with almost no maintenance.

To see how food service is handled in other hospitals of 100 beds or more, send for free Bulletin 1502. And . . . ask your architect about Olson equipment.

OLSON CONVEYORS

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ALL NEW!



WASHER

ROTARY machines

FOR FAST LOW-COST SURGICAL GLOVE PROCESSING



DRYER



POWDERER

The fastest, easiest and *most economical way* to process surgical gloves is the Rotary way.
For example: Even in a 100-bed hospital, these three companion machines will pay back their cost in actual savings over the hand method in less than a year.

WASHER Developed expressly for surgical gloves. Three times faster than hand method. No punishing agitators or fast rotating drums. Unique pulsating action cleans gloves thoroughly inside and out. Water drained automatically at end of each cycle. Takes only 8 minutes of operator's time. Capacity 150 gloves.

DRYER Faster, safer, because warm air at safe temperature is blown directly and continuously into tumbling drum . . . revitalizing the gloves as they dry. Excess water is removed at start of drying cycle. Drying time 30 minutes . . . three times faster than by hand. Capacity 150 gloves.

POWDERER Ten times faster than hand method. Even coating of powder, inside and out, without turning. Airtight. No powder escapes. Powdering time 4 to 8 minutes (depending on thickness of coating). Capacity 150 gloves.

FREE! GLOVE PROCESSING MANUAL mailed on request with illustrated literature describing the all-new Rotary line.



ROTARY HOSPITAL EQUIPMENT CORP.
1740 Dale Rd. Buffalo 25, N. Y.

• **Catalog No. 60,** covering food service equipment manufactured by Caddy Corp. of America, Secaucus, N.J., is now available. It includes data on such newly developed mobile units as the Wet Tray Caddy T-222, the Nylon "DB" Belt Caddy-veyor for large-scale dish, tray and rack transfer, and other items.

For more details circle #257 on mailing card.

• The **No. 80 Series Twin Light Catalog** describes the features of the Castle Twin Light, designed with two separate light sources to provide depth of illumination in surgery. Available from Wilmot Castle Co., 1941 E. Henrietta Rd., Rochester, N.Y., the 12-page bulletin contains descriptive data, cut-away views, general specifications and captioned photographs showing suggested light positioning for Twin Light applications, and includes a special section on maintenance.

For more details circle #258 on mailing card.

• **Aristocrat IV Filing Cabinets** are described in **Brochure LBV 743** available from Remington Rand Div. of Sperry Rand Corp., 315 Park Ave. S., New York 10. The 12-page booklet lists and illustrates the models and accessories included in the Aristocrat IV line and contains suggestions for efficient and economical filing systems.

For more details circle #259 on mailing card.

• **Miscellaneous hardware for schools, hospitals, colleges and other institutional construction** is the subject of a new catalog issued by The Yale & Towne Mfg. Co., 11 S. Broadway, White Plains, N.Y. Information is included on door pulls, holders, bumpers, silencers and stops; bolts; drawer pulls; push plates; casement fasteners, and other hardware.

For more details circle #260 on mailing card.

• Actual surgical cases are pictured in the new color-sound motion picture which demonstrates achievement of more stringent skin asepsis during surgery with use of a transparent surgical drape. The 16mm 17-minute film produced by Robert M. Zollinger, M.D., William G. Pace, M.D., and Marjorie J. Reed, R.N., Department of Surgery, Ohio State University, is entitled **"A New Transparent Plastic Surgical Drape."** It is designed for showing to surgical and medical staffs, residents, interns, students, hospital staffs, O.R. nurses and Infections Control Committees. It describes the use of the new barrier to wound infection in a wide variety of surgical specialties, including abdominal, orthopedic, gynecologic, neurologic and thoracic. A descriptive folder and application for scheduling of the film may be obtained from Aeroplast Corp., Station A, Box 1, Dayton, Ohio.

For more details circle #261 on mailing card.

• A colorful new 16-page **brochure of Toilet Enclosures** is available from Fiat Metal Mfg. Co., 9301 Belmont Ave., Franklin Park, Ill. Stressing the advantage of five strategically located plants for fast service to any point, the catalog pictures and describes the types of enclosures, screens and partitions manufactured by the company, with line drawings of installation data and actual samples of the eight decorator colors in which the equipment is supplied. Featured is the Fiat 100-year hinge which operates quietly and smoothly with no maintenance whatever. It is described as a self-closing hinge that cannot corrode, never wears out and has a bearing surface of the only working part made of DuPont Zytel Nylon, self-lubricated for life.

For more details circle #262 on mailing card.

• An inexpensive folder, designed for distribution to visitors of patients in hospitals, is available with your hospital's name on the front cover, from E. B. Rossman Associates, 17621 James Couzens, Detroit 35, Mich. Entitled **"Visitors Information,"** the attractive pamphlet is pocket sized and is laid out and illustrated to encourage reading by visitors. Visiting hours and other pertinent rules and regulations of the hospital are presented pleasantly yet firmly. Samples of the folder, adaptable to the need of each institution, are offered.

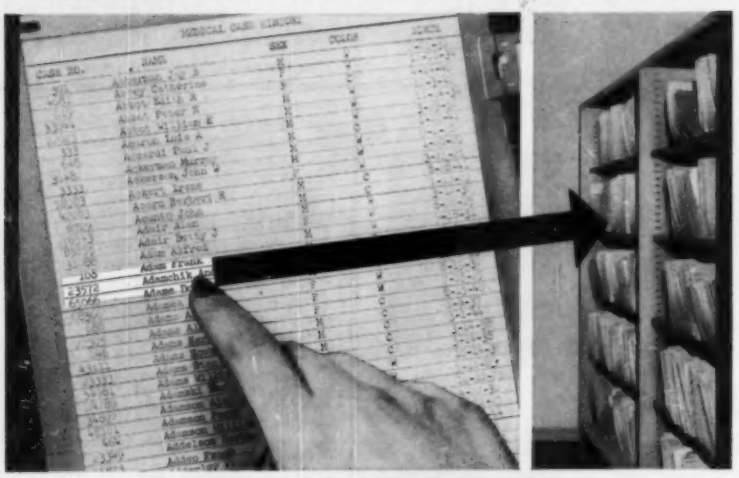
For more details circle #263 on mailing card.

Supplier's News

Owens-Illinois Glass Co., Toledo 1, Ohio, announces acquisition of **Keystone Brass Works, Erie, Pa.,** maker of plastic melamine dinnerware and cast bronze solder fittings. Operation of the melamine dinnerware plant will be under the **Libbey Glass Division of Owens-Illinois,** adding plastic dinnerware to the line of fine glassware manufactured by Libby.



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ACME VISIBLE Flexoline Master-Index Systems save reference time and effort

Just a flick of a finger locates a medical record on your Acme Flexoline "reference rotary." You can economically cross-index a few hundred or many thousands of listings in limited space. As cases accumulate, new listings are easily added, in sequence. Simply type a new listing on a Flexoline sheet and separate the strip . . . insert it in the metal frame for quick cross-reference to your case history files. Perfect for an alphabetical index to x-ray films, too. Our experienced field men will advise you on hospital record systems tailored to your needs . . . or you may write for FREE detailed booklets about the varieties of Flexoline systems. MAIL THIS COUPON TODAY!

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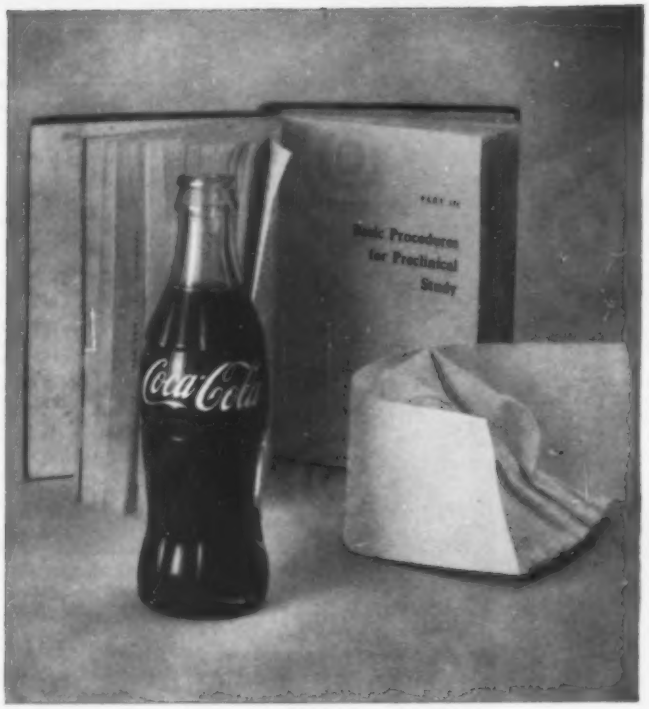
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Title_____

Hospital_____

City_____ Zone____ State____



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

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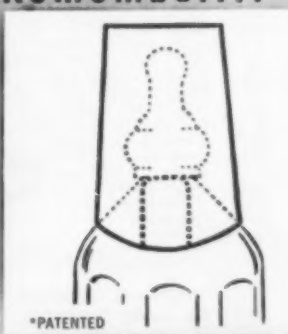
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- minimize handling, keep SMo surgical implants free from nicks and scratches
- made of special porous material to assure sterility, withstand repeated autoclaving

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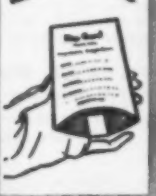


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provide space for identification and formula data . . . instantly applied to nipple; save nurses time...cover both nipple and bottleneck. Do not jar off. No breakage.

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"Hospital designed" Maysteel casework reduces the nurse's burden



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More than beauty and color, Maysteel Baked Enamel finishes are porcelain-like in their hardness and resistance to abrasion and cleaning solvents — for years of like-new appearance.

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Solid, double-paneled doors and drawers, sound-deadened, with silent hinges, rollers, slides or soft rubber bumpers — provide for quiet operation of every moving part of Maysteel Casework



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It's a wise administrator who has at his fingertips up-to-date information on new developments in equipment and materials which will serve his institution best. Look at the numbers in the yellow sheet in the back of this issue. Each advertiser listed in the index has an identifying number—so does each entry in the "What's New" section. Use these numbers on the yellow postage-paid return cards to request information on products in which you are interested—to be sure the product information you need is in your hands and current.

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061102

New floor tile discovery from Romany·Spartan...

CERAMAFLEX*

rubber-cushioned ceramic mosaics

in 9″ squares

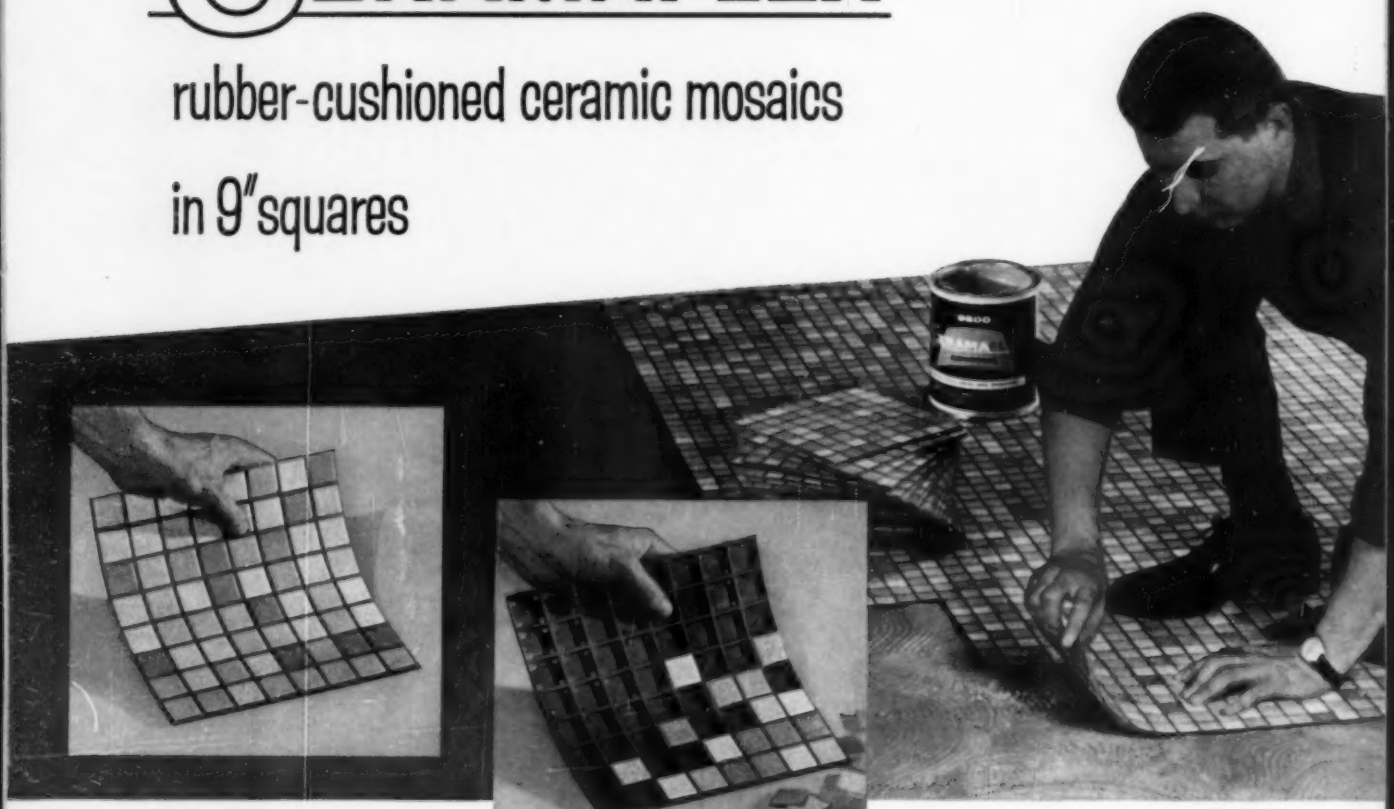


Photo No. 1099

It's flexible and resilient!

Ceramaflex, because of its unusual flexibility, adjusts automatically to minor imperfections in sub-floor. But the rubber grid which makes this possible serves other functions, too. Ceramaflex floors are quiet because they are mounted in *resilient* rubber which acts as a cushion between the ceramic mosaic tiles and the sub-floor, and they are easy on the feet. Heavy furniture and appliances can be moved without denting or harming the surface.

Tiles are mounted in rubber pockets!

Each of the 64 ceramic mosaics that make up one 9″ x 9″ unit is permanently bonded in a pre-formed rubber grid. Because the edges of Ceramaflex 9″ x 9″ units are beveled, they lay up so tightly that joints are unnoticeable in the finished job.

So easily installed!

Because Ceramaflex is pre-grouted, installation is simple and fast. It's ready for use the instant it's laid. Ceramaflex is installed with a special adhesive as quickly and easily as conventional resilient floor tile. It can be installed satisfactorily on or below grade as well as above grade, over proper sub-flooring. Simple, rapid installation results in application cost substantially lower than that of conventional ceramic mosaic floors.

Never has a flooring material offered so many advantages for hospital use as does Ceramaflex. This labor-saving, high quality product embodies all the most-wanted qualities of ceramic tile, plus *two important additions:* floors that are both *quiet* and *easy on the feet*. Here's the carefree beauty and permanence of ceramic tile in low-cost, easy-to-install form. It's dentproof, stainproof and fireproof, and once-over with a damp mop keeps it fresh and sparkling. This makes resilient Ceramaflex a superior flooring for lobby, corridor, kitchen, bath, washroom, utility room and scrub room.

Ceramaflex is as *new as tomorrow*. If your architect doesn't yet have his samples, he'll be glad to get them. Ask him about Ceramaflex, or write for Bulletin RS-228. United States Ceramic Tile Co., Dept. MH-13, Canton 2, Ohio.

**Trade Mark. Ceramaflex is the exclusive product of United States Ceramic Tile Company.*

ROMANY SPARTAN

CERAMIC TILE

PRODUCT DATA

CONSTRUCTION. Made of Romany-Spartan unglazed 1″ x 1″ ceramic tiles which are securely bonded in a flexible rubber grid.

DIMENSIONS. Ceramaflex flooring units are 9″ x 9″ squares... and 7/32″ thick. Each Ceramaflex floor unit is composed of 64 ceramic mosaic tiles approximately 1″ x 1″.

FINISH. The surface of Ceramaflex is sealed at the plant with a protective coating to prevent wearing-in of dirt and grime.

COLORS. Random medley patterns in twelve handsome color combinations.

MEMBER

UNITED STATES CERAMIC TILE COMPANY